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Khomanani: Critical Discourse Analysis of South African State Funded
Publications on HIV

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, or other people has been attributed, and has been cited and referenced.

Signature: Elizabeth Aulette-Root Date: 08/12/08

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Abstract

South Africa has been named as one of the countries most strongly impacted by the HIV pandemic. As of the end of 2007, an estimated 28.6 million people worldwide were living with HIV. In that year 2.7 million people became newly ill with HIV and an estimated 2 million people lost their lives to AIDS. Two thirds of people who are living with HIV, and three quarters of people who die as a result of the illness are from the area of Sub-Saharan Africa (UNAIDS 2008). The South African government has responded to the high numbers of South African people who are becoming ill, living with, and dying as a result of HIV in various ways. One way is through government funded media campaigns that provide information on “prevention, care, treatment, and support” with regard to HIV (Khomanani 2008m). Khomanani: Caring Together is a programme of the South African Department of Health that creates publications on HIV. These publications are free, widely distributed, and governmentally promoted. The Khomanani texts necessitate critical research. The present study focuses on identifying the discourses that emerge in these official documents. A data set of the complete collection of Khomanani booklets and leaflets in English was discursively analysed. The analysis focuses on ways in which emergent discourses in the text maintain or resist existing power structures in the context of post-colonial South Africa. The discourses that emerged are: hegemonic biomedicine, gender, and citizenship discourses. The discourses in the text reinforce dominant and oppressive power structures in complex ways and necessitate a critical reworking in order to more successfully address HIV education in South Africa.

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Chapter One: Introduction

This thesis will explore the texts of the Khomanani Programme, a media campaign produced by the South African government on HIV and AIDS. The Khomanani Programme was introduced to the public in 2005 and is ongoing. The purpose of this programme is to engage in a media campaign to respond to HIV by educating people about what they must do to protect themselves from HIV and how to treat and care for people living with the illness (Department of Health 2005).

Through a critical discourse analysis of this data set of texts, the documents produced by the Khomanani Programme, this thesis seeks to identify and describe the character of the official governmental position on HIV that is put forth by the texts. A critical analysis has been done of all of the booklets and leaflets from Khomanani that are available in English, and which are about various aspects of HIV prevention, care, and treatment. This analysis critiques the positions expressed in the material through an exploration of the underlying political message of the texts by looking at the power relations that are represented. The focus of this research is on how the discourses that emerge in the data set maintain, as well as challenge, existing power relations.

This thesis looks at themes, topics, and discourses on HIV and AIDS that are taking place currently within these official South African government publications. The governmental discourse represented in the text exists under the umbrella of the larger 'Official' Discourse that is generated by a broad array of individuals and institutions throughout the world (Jagger 1997). The South African government's discourse is a particularly significant piece of the larger international official discourse because South Africa is a major site of the HIV crisis and because the South African government has

taken an active, and sometimes controversial, role in addressing the local and global epidemic.

1.1 Addressing HIV and AIDS in South Africa

The Human Immunodeficiency Virus, HIV, is one of the worst public health events in human history. By the end of 2007, an estimated 28.6 million people worldwide were living with HIV. In that year 2.7 million people became newly ill with HIV and an estimated 2 million people lost their lives to AIDS (UNAIDS 2008). The United Nations also reports that, “Sub-Saharan Africa remains the region most affected by the AIDS epidemic, with more than two thirds (68%) of all people infected with HIV living here...[and] Southern Africa accounted for almost a third (32%) of all new HIV infections and three quarters (75%) of AIDS-related deaths globally” (UNAIDS 2008, 32).

Zachie Achmat and Julian Simcock, two political activists from South Africa who have become leading voices in the discussion of HIV, describe the particular impact of the HIV pandemic on South Africa saying that, “women aged between 24 and 44 years are disproportionately affected by AIDS-related deaths. These deaths occur during the peak years of an individual’s economic and child-rearing productivity, reshaping the fabric of society” (Achmat and Simcock 2007, 13). South Africa has, thus, been named in both global and local discourse on HIV and AIDS as a country that has been most strongly impacted by the virus. As a response to the effects of HIV and AIDS on South Africa, a number of media campaigns have been launched to address the problem by government, NGOs, and a combination of both (Zungu-Dirwayi et al 2004). The

Khomanani Programme, which is exclusively governmentally funded, is designed to educate the public about HIV and AIDS and is among the largest and most significant of such programmes (Department of Health 2005; Dlamini 2007).

The texts from the Khomanani Programme were chosen for analysis because they are so significant. They are free, current, extensively distributed, officially funded from public monies, and published by the government. Many of these texts are widely available from either public health clinics, HIV support groups in some communities, online via internet document, or by ordering the complete set of hard copies of materials from the Khomanani offices. Together, all of these factors indicate that the texts are likely the most widely read literature on HIV and AIDS by people in South Africa, having the largest impact on, or importance for, this population.

These texts are also necessary to examine because they reflect the official word of the South African government. It can be assumed that what the state considers to be the Official statement on HIV and AIDS is central to these booklets and leaflets which are being mass-produced by the government body. However, what the state 'says' about HIV and AIDS is not always the same message that can be found in the information they actually disseminate. Governmental publications can sometimes be contradictory to official government statements, even as these texts are directly attached to government both in their production and distribution. The Khomanani publications are produced with government funds, written by people chosen and employed by governmental offices, and distributed through social institutions, such as public health centres, schools, community centres, and libraries (Department of Health 2005).

The recent date of publication of these texts—from 2005 through this year and continuing into 2009—is significant as well. Various discourses have emerged and been developing over the past few decades in regard to HIV and AIDS (Treichler 1999). The Khomanani texts are the latest expression as they are currently being produced and disseminated. It can be assumed that these texts reflect what the government has deemed as recent and relevant information pertaining to HIV and AIDS in the South African context. Although this analysis of the Khomanani Programme is a specific and relatively small scale case study, it examines an important set of texts that fit into the larger more complex picture of the experience of HIV in South Africa and the world.

The realm of discourse plays an inextricable role in the ways people are experiencing and dealing with HIV and AIDS. The fight to end stigma and ensure access to treatment, as well as to reduce the risks of infection and transmission of HIV, are extremely important. Equally important, however, is the struggle to understand and influence ways of thinking, talking and writing – the discourses in which these issues are immersed. It is important to be aware that, although a response to the physical and biological effects of HIV and AIDS is of the utmost urgency, HIV and AIDS are not solely medical concerns (Fassin and Scheider 2003). The sociopolitical battle takes place through, within, and by means of discourse on HIV and AIDS.

1.2 Critical Discourse Analysis

Discourse creates and reinforces the context within which any action takes place. Edward Said argues that, “ideas, cultures, and histories cannot seriously be understood or studied without their force or more precisely their configurations of power also being

studied” (Said 1978, 5). Said is saying that unless we identify and understand the sources and purposes of the knowledge being produced, reproduced, and resisted in our world, *as well as* the relationship between this knowledge and power structures, we can never ‘truly’ understand any of the knowledge we acquire in our lives. The social and political character of HIV, therefore, cannot be understood without examining the texts that present information about HIV, such as the Khomanani literature, and the ways these texts reproduce or resist relations of power.

Structures of power are created and maintained through discourse. Discourse cannot be abstracted from its political roots and context. In order to successfully engage in activism one must work to fully understand the field of battle. The ways that discourses, especially as they are presented by official bodies, construct the ‘objective facts’ must be closely analysed. In the case of HIV and AIDS, in order to understand the issues, and, especially, in order to effectively address them, the discourses in which the sources of given information about HIV and AIDS are immersed must be identified and critiqued.

The ways in which people think, write, and talk about HIV and AIDS vary broadly and come from myriad sources. However, the discourse created, maintained, and promoted by people and groups with power, such as the state, are perhaps most significant (Berberoglu et al 2007; Evans et al 1985; Giddens 1987; Therborn 2008). This discourse is more important because of the expectation that the state both speaks to and for the entire groups of people defined as ‘citizens.’ State or official discourses counsel with great authority. The state is a large and powerful entity and it is assumed that, because of its size and authority, the state has access to wealth, resources, and the

machinery of government. For example, in contemporary societies the state usually has the sole power to tax, to arm itself, and to control the economy, schools, health care and every other aspect of its citizen's lives (Skocpol and Amenta 1986; Giddens 1987).

Based on this assumption, the state's official stance, whether it is one single stance or a combination of statements possibly contradictory to one another, that is being put forth through mass media or education campaigns on a particular subject becomes a discourse that should or must be followed by all citizens under its control (and supposed protection). Furthermore, the power and wealth of the state also makes it appear that the information it disseminates and the subsequent discourses that emerge from it would be based on thorough research which would be beneficial to its citizens.

In the case of South Africa, this authority is further enhanced because of the position of South Africa as one of the chief political and economic forces on the African continent (Alden and Soko 2005, 369). In addition, South Africa, because its citizens have been so devastated by HIV, and because it is a nation identified with justice and a commitment to building a new society, has great moral authority (Nattrass 2003, 179). The power of the South African state reaches far beyond its borders and the actions South Africa takes that contribute to the discourse on HIV are significant.

Along with this authority comes responsibility. South Africa is under great pressure not only to set standards in addressing issues surrounding HIV and AIDS, but to develop a humane and effective response to the pandemic. The government of South Africa will be judged on its ability to use its resources wisely to reduce and eliminate illness from HIV (Benatar, 2001). Success in dealing with the virus, the experience of the illness, and all of its sociopolitical ramifications is very much based on planning and

providing access to resources. The governmental response in the form of policy which results in the provision of information and instruction on accessing resources, through educational campaigns, deserves critical analysis.

Policy is the means by which government carries out its responsibilities. Policies are mechanisms by which governments run nations. They are the lines of action that allow countries to extract resources from and control people residing in them (Hill 2006). Social policies are government “activities affecting the social status and life chances of groups, families and individuals” (Skocpol and Amenta 1986, 132). Welfare grants, public health initiatives, public schools, public housing, and worker’s health and safety regulations are all examples of social policies. Scholars and governments have identified education as a central tool, and the most significant policy area in regard to combating HIV and AIDS (Piot 2001). The management and the education of large groups of people are specific responsibilities of government. Providing for the health care needs of people who are living with HIV by developing and distributing educational materials for the prevention of infection and transmission of HIV, through governmentally produced programmes such as Khomanani, are features of social policy. Many people get most of their information from the state via programmes based on this kind of policy. It is, therefore, important to the public that government sponsored texts be critically examined.

1.3 Khomanani: The Discursive Case Study

In South Africa a broad array of programmes addressing HIV and AIDS have been introduced by the state and by NGOs as well. Many of these efforts are designed to provide treatment for those living with HIV, but a significant emphasis has been and

continues to be on preventing infection and transmission. These institutions attempt to prevent transmission through education about HIV by increasing health literacy among the public and by presenting alternative identities in attempts to change behaviour in ways which would encourage people to take better care of their health and decrease behaviour that puts them at risk of exposure to HIV. For example, the Soul City Institute, the Beyond Awareness Campaign, and the Love Life Programme have been active in the 1990s and 2000s (Zungu-Dirwayi et al 2004). All of these groups combine media campaigns—using media such as booklets, leaflets, posters, advertisements, concerts and television programmes—and community outreach to provide HIV education for South Africans. Funding for the Soul City and Love Life programmes has been provided by a combination of resources from the South African government and various international and national NGOs and funders (Soul Beat Africa 2002; Soul City 2008). The sole funding of the Beyond Awareness Campaign, however, was provided by the South African Department of Health (Soul Beat Africa 2003).

The current governmental health literacy programme put forth by the Department of Health in South Africa is Khomanani: Caring Together, which consists of an organisation which produces an HIV, AIDS, and TB awareness media campaign. The goal of this health literacy programme is to create texts, in the form of booklets, leaflets, poster, pins, calendars, and stickers, which will educate South Africa citizens about HIV, AIDS, and TB.

The Khomanani Programme was initiated in August 2001 as the communication campaign of the South African government's "five year strategic plan" to "deal with HIV" (Department of Health 2008). Initially developed as a two year plan, the

Khomanani Programme was implemented with a R190 million budget (Department of Health 2007). The tender was awarded again over the next 4 years and Khomanani was most recently reinstated in 2007 for two years to end in 2009. The “vision” for Khomanani for 2007-2009, according to the statement on their website, is, “all about developing simple, innovative, and effective messages that will continuously promote healthy living and contribute significantly to the acceleration of HIV prevention, treatment, care, and support among all South Africans” (Khomanani 2008m). The theme of “support” in the 2007-2009 campaign was added to the original themes of “prevention, care, and treatment” in the Khomanani descriptions.

According to their official website, the media produced and distributed by the Khomanani Programme are based on these themes of “prevention, treatment, care, and support” (Khomanani 2008m). Their self-description also identifies “five integrated focus areas” for the 2007-2009 campaign: “Accelerated Prevention;” “TB and HIV;” “Treatment, Care and Support (TCS);” “Nutrition;” and “Health Promotion” (Khomanani 2008m). Khomanani also names ten “broad objectives” of the campaign:

- Improving knowledge and positive attitudes towards healthy lifestyles
- Promoting health seeking behaviours among South Africans
- Increasing the sense of personal risk of HIV infection, and increasing and sustaining the attitude of greater responsibility for sexual behaviour
- Decreasing the risk of women becoming infected with HIV through increasing attitudes of gender equality among both men and women
- Contributing in reducing stigma and discrimination amongst people living with HIV
- Promoting and increasing demand for Voluntary and Confidential Counselling and Testing (VCCT)
- Increasing individual and community support for orphans and other vulnerable children (OVCs) or children in need
- Improving health seeking behaviour for TB adherence to treatment
- Improving knowledge about good nutrition to increase longevity and enhance quality of life among communities, people living with HIV (PLWH) and service providers

- Supporting health workers in their management for people living with HIV and AIDS, TB and STIs (Khomanani 2008m)

Like the previous sets of “themes” and “integrated focus areas,” these “broad objectives” are indeed broad, as well as complex and somewhat vague, especially in their position as a plan of action set forth by the organisation. This thesis seeks to make more explicit some of the underlying themes and objectives that are present in the Khomanani texts by exploring the discourses that emerge in the Khomanani brochures and leaflets on HIV and AIDS.

1.4 Research Question

The research questions in this critical discourse analysis are: What discourses emerge in the Khomanani documents? What discourses are absent? And how do the discourses reinforce or resist existing power structures?

Chapter Two: Theory and Methods of Critical Discourse Analysis

Critical discourse analysis is a broad field with many contending schools of thought (Zglobiu 2007). This chapter outlines critical discourse theory and analysis, and shows how the method has been applied in this thesis in the examination of the Khomanani Programme's texts on HIV and AIDS. An argument has been made for why this method is most appropriate for the interests of this research.

2.1 Critical Discourse Theory

The method of critical discourse analysis as a tool in the examination of texts is based on Foucauldian critical discourse theory. The importance of Michel Foucault's theory lies in his reworking and redefining of the concept of 'discourse,' and its ability as an entity to be critically analysed in relation to knowledge and power. Whereas linguistic and sociolinguistic traditions have focused on the structure and content of language, more recently social theorists such as Foucault, illuminate the ways power is inextricable in language and systems of representation (Fairclough 1989, 12). Foucault's definition of discourse has been described by Iara Lessa as, "systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak" (Lessa 2006, 289).

In contrast, linguistic and textual analysis that is done in purely a structural context explores languages in their use by individuals for conversing. This is done by examining how language conveys and expresses information between people or groups of people as they interact with one another as speakers and listeners, or writers and readers. Conversations and texts can also be examined for conceptual ideas and themes.

Sociolinguistic analysis is concerned with identifying and investigating the expression of paradigms in discourse (McHoul and Grace 1993). Although these kinds of non(or less)-critical investigation of texts provide some information about what is being ‘said,’ they omit the important aspect of power and its construction through the social production of knowledge.

Foucault contributed to conceptualizations of discourse and discourse analysis by focusing on dimensions of power. Discourse analysis, according to Foucault, includes the examination of areas of social interaction and ways of conveying knowledge with an added critical aspect which relates ‘discourse’ to power. For Foucault, power is constantly being asserted and contested in daily interactions among people and those interactions often take the form of discourse. Alec McHoul and Wendy Grace further clarify this critical Foucauldian view of discourse, stating that,

Among critical discourse theorists such as Foucault, the term ‘discourse’ refers not to language or social interaction but relatively well-bounded areas of social knowledge... ‘A discourse’ would then be whatever constrains—but also enables—writing, speaking, and thinking within such specific historical limits. (McHoul and Grace 1993, 31)

When McHoul and Grace describe this ability of discourse to simultaneously “constrain” and “enable,” they are describing an important aspect of Foucauldian critical discourse theory. By being aware of the ways in which knowledge can be used to “constrain” and “enable” the things that we think about, and the very ways in which we communicate and interact with each other in a social world, we become aware of power. Within a Foucauldian framework, knowledge has now been identified as a tool, not merely a way of ‘accidentally’ or ‘naturally’ grouping ideas and meanings together. Foucault (1978) argues that through the use of this tool—knowledge—powerful people

exert power and control over less powerful people by telling them what is possible to know.

Care must be taken when considering the role of power in discourse. Discourse should not be interpreted as something purposefully or consciously created by powerful people in order to maintain social control. Foucauldian discourse is rather an interaction of knowledge and power (Foucault 1980). Power is embedded in the knowledge we have that is expressed in language. Power creates and sustains knowledge. But knowledge also shapes power.

According to McHoul and Grace,

[Foucault] Locates power outside conscious or intentional decisions. He does not ask: who is in power? He asks how power installs itself and produces real and material effects; where one such effect might be the particular kind of subject who will in turn act as a channel for the flow of power itself. (McHoul and Grace 1993, 21)

Foucault, then, is arguing that it is not an awareness of the intention that is necessarily what is important in discourse. What is more significant is what the discourse actually reinforces. In the analysis of texts, therefore, using a Foucauldian framework, we must focus our attention on what the texts *do* rather than what their creators may have intended for them to do.

2.2 African Theoretical Context

Although Foucauldian discourse theory has been lauded for its contribution to the ways in which language and knowledge link directly to social experiences of power and violence, for African—or Non-Western—scholars this theoretical framework creates a paradox when used as the sole theoretical basis for research. Manthia Diawara argues,

The pure discourse criticism, which is part of a particular culture, enables non-Westerners to denounce the domineering presence of the West in their texts, but paradoxically does not allow them to move forward and create a discourse outside the Foucauldian system. (Diawara 1990, 87)

Many of the knowledge and power relations that we uncover through the practice of critical discourse analysis in the global South will undoubtedly involve structures, institutions, and practices that are connected to, and immersed in a global history of Western/European slavery, colonialism, apartheid, exploitation, and imperialism. The contribution that critical discourse analysis makes, therefore, is a disclosure, acknowledgement, and critique of ideas and discourse that have appeared as 'natural' and 'neutral,' but in fact have served to bolster and reproduce the oppressive and exploitative political relations from which they originated. The paradox is that as we are engaging in an analysis of these knowledge and power relations we are doing so based on theory that has been identified, articulated, and attributed to a European scholar in a European context.

Discourse theory describes the ways in which knowledge and power interact in our social worlds. The concept that knowledge and power are inextricably linked, and that these links require attention and analysis, is important to and useful for all kinds of thinkers and scholars globally. However, being aware of the particular issues, experiences, and discourses that surround and immerse an entire group or location of people before setting forth in critical discourse analysis, is also a necessity. This is the case in the South African and African context of present research. Post-colonial theory, therefore, must be linked to critical discourse theory during the analysis of these African texts.

Post-colonial theory is based on the historical construction of the 'Other' in opposition to the Western world, what Edward Said (1978) defines as "Orientalism". Although Said describes Orientalism as the relation between Europe and the "Near East," this conceptualisation also defines the relations between the West/Europe and the various nations under its control since the beginning of Western expansion and colonisation of many countries in Africa, the Arabian Peninsula, Asia, and the Americas. This construction of an Other has for many centuries played, and continues today to play, a central role in most hegemonic discourses on an array of international topics, including the existence of HIV and AIDS in African countries. Said argues that,

Without examining Orientalism as a discourse one cannot possibly understand the enormously systematic discipline by which European culture was able to manage—and even produce—the Orient politically, sociologically, militarily, ideologically, scientifically, imaginatively...so authoritative a position did Orientalism have that I believe no one writing, thinking, or acting on the Orient could do so without taking account of the limitations or thought and action imposed by Orientalism. (Said 1978, 3)

Because of this history and ongoing positioning of 'the West and the rest,' there are very real material and discursive battles taking place in which African or Non-Western groups and locations of people seek to disentangle themselves from oppressive constructions and existences. V. Y. Mudimbe (1982, 39) asserts that, "Michel Foucault, because of his influence, his originality, and the significance of his work, may be considered a noteworthy symbol of the sovereignty of the very European thought from which we wish to disentangle ourselves."

For the purposes of this thesis it should be clear that, although Foucauldian concepts of discourse are used as a theoretical framework, it is done so with a consciousness of what that means—or requires—in an African context. Furthermore, the

analysis will pay close attention to issues raised by post-colonial theory in regard to the emergent discourses that are reviewed and will use critical discourse analysis to critique those discourses.

2.3 Methods

Critical discourse analysis is based on Foucauldian theory and is a tool used to critically analyse texts. When engaging in formal analysis and interpretation of a text through critical discourse analysis, one must be aware of the context of the social world in which the text was created, as well as the context of the social world in which its interpretation and reinterpretations occur. Norman Fairclough (1989) describes this interaction of textual, as well as discursive analysis, by illuminating the simultaneous levels of analysis necessary in critical discourse analysis of texts. He writes, “Text analysis is correspondingly only part of a discourse analysis, which also includes analysis of productive and interpretative processes” (Fairclough 1989, 24).

Fairclough emphasizes the importance of acknowledging that speaking and writing are not individual acts, but rather acts which are entrenched in social and political relationships and the institutional, structural, and ideological forces that form the organisation of power in those relationships. Therefore, the text cannot stand alone as a body of analysis outside of the context in which it was created and the context in which it will be read, interpreted, or reproduced.

Fairclough (1989, 25) defines these contexts as the “social conditions of production” and the “social conditions of interpretation.” During critical discourse analysis, the researcher is simultaneously analysing the text itself, as well as the “social

conditions.” In the present analysis of Khomanani texts, it was important to be simultaneously concerned with what was written and the context in which the information had been produced and consumed. For example, it was important to be aware that the expansive information regarding ARVs (anti-retrovirals) in these government funded brochures and leaflets was produced in the context of legal battles to provide access to these medicines for all South African citizens (Medecins Sans Frontieres 2008).

ARVs have become the centre of a storm of international controversy and debate. Because they are expensive, international pharmaceutical corporations, governments which have agreed to treaties that protect patents, local governments which make policy decisions regarding spending on drugs, and activist organisations concerned about gaining and retaining access to a means to their survival have all entered the fray in this struggle. Any information provided about the benefits or accessibility to ARVs in the Khomanani Programme literature, therefore, must be understood within this politically charged context (Hassan 2004).

2.3.1 Technique for Conducting Analysis

In order to begin discourse analysis, it is necessary to find an entry point or way of critically engaging with the text beyond repeated readings. Ian Parker (2004) has suggested a specific protocol to follow as a procedure for undertaking critical discourse analysis. Parker’s (2004) method involves the identification of “objects” in the text through the primary identification of nouns used in the text.

According to Parker (2004, 310), nouns in a text mark the objects of analysis by identifying them and researchers can, “treat the text itself as the object of study rather than what it seems to ‘refer’ to.” Through this entry point of noun identification, we can begin to identify themes and later discourses in our data set of texts. With the use of this method the identification of nouns leads directly to the identification of ‘objects’ in the text. Once the objects of the texts, such as particular terms or particular constructions, have been identified, discourses will emerge as well. The nouns were not tabulated as this research was not concerned with quantifying particular nouns. Rather, this method was used to illuminate the character of the particular discourses in the texts. As the texts were analyzed, it was noted if specific nouns, for example “HIV,” “pregnancy,” or “grant,” occurred often, but only as evidence that a particular theme or discourse appeared across and throughout the texts. The discursive objects that were constructed and maintained through the texts were also extracted from the collection of nouns, for example “patients” or “health workers.” By concentrating on nouns as an identifiable part of text, it is possible to engage with the text analytically rather than simply ‘reading’ it. This method of noun identification facilitated the emergence of discourses, as well as the analysis of the ways in which the discourses ‘work’ together or exist as a coherent interacting entity.

In this critical discourse analysis of the Khomanani texts each of the seven booklets and the ten leaflets that have been produced (Appendix A) were read and critically analyzed according to Parker’s (2004) method. During this analysis, distinct discourses emerged and could be identified within each booklet or leaflet individually, as well as across the data set of texts. Three main discourses emerged: ‘Hegemonic

Biomedical Discourse,’ ‘Gender Discourse,’ and ‘Civic Discourse.’ These discourses interact under the umbrella of ‘Official Discourse’ of the South African government through its creation and distribution of the Khomanani texts.

2.3.2 Ideological Function of Discourses

Part of the ‘work’ a discourse does in a text is in the maintenance of, or resistance to, structures of power. Discourses have the ability to either reinforce or challenge—or likely do a mixture of both—existing structures of power. This reinforcement or resistance is referred to by Andre Du Toit (1994) as the “ideological function” of the discourse. Critical discourse analysis seeks specifically to evaluate the ways in which these discourses have ideological function and meaning. According to J. B. Thompson (1984, 131), an ‘ideology’ can be described as, “the ways in which meaning (signification) serves to sustain relations of domination.” This interaction of discourse and power is what Thompson (1984, 130) refers to as “ideology.” Although conceptualising discourses and their relationships to domination and power in this way is helpful, defining discourses as either ideological and working only to sustain the status quo, or *not*, can become problematic. This way of classifying discourses leaves out the human nuances of power structures. It is not precise enough to simply categorise a discourse as *either* ideological or not. We must determine *how* ideological a discourse is.

Categorising discourses within a dichotomous grouping of either ‘ideology’ or ‘not ideology’ may seem to be a straightforward response to questions of power relations that take place through a particular discourse. However, Du Toit’s (1994) adjectival conceptualisation of the relationship between discourses and power relations was used in

this critical analysis in order to avoid an incorrect oversimplification of discourses into easily categorical components. An adjectival use of 'ideological' as opposed to 'ideology' allows us to describe, rather than label as one or the other, how strongly a discourse reinforces existing power structures, or resists them. In this way we can describe the relation of power and knowledge in a particular discourse in more detail than simply identifying it as an 'ideology' or 'not an ideology.' Du Toit (1994) suggests that we assess the ways in which discourses create and maintain relations of domination, or not, rather than assume that there are clear-cut 'ideologies' that are distinct from 'something else' such as 'science' or 'truth.' Classifying ideas in this fashion is very dangerous as it oversimplifies the analysis and disregards the intermingling of resistant and oppressive knowledge. Since discourses most often cannot function as *only* oppressive or resistant, ideological or non-ideological, labeling them as such may deter a critical analysis of how they are actually reflecting and reinforcing power structures, and who they benefit.

Popular and denialist discourses on HIV and AIDS in South Africa, for example, are often posited as simply 'ideological,' meaning oppositional to the 'objective' or 'scientific' biomedical discourse on HIV. Denialist discourse in South Africa is the discourse which has most often been attributed to former President Thabo Mbeki, who purportedly argued that HIV did not cause AIDS. Statements such as this, combined with the government's previously strong resistance to ARVs and other medical treatment for HIV being made readily available for South African citizens, make up the denialist discourse (Nattrass 2007). Denialist discourse could be described as 'ideological' because it upholds these oppressive power relations. This discourse is highly

problematic, and *does* reinforce political power structures where governments have the ability to choose whether or not to allow citizens to in fact *live*. The denialist discourse however, cannot be simply explained away as discourse that is ‘an ideology’ created through ignorance; unwillingness on government’s part to educate themselves and citizens; or willingness on government’s part to deny treatment to citizens simply because they can.

Denialist discourse is not only ‘ideological,’ but rather a mix of different levels of ideological function involving resistance and reaffirmation of existing and exploitative power relations between Africa and the West, South African leaders and South African citizens, and biomedical doctors and traditional healers. Mbeki’s denial was not of science, but rather of ‘Western’ science, and the preoccupation with ‘treatment’ that ignores sociopolitical and socioeconomic aspects of HIV and HIV treatment (Fassin 2007). Denialist discourse, although maintaining an oppressive and paternalistic relation between the South African government and South African citizens, promotes a resistant stance to oppressive and paternalistic relations between Africa and the West (Wang 2008). This discourse has had a great impact on people living and dying and cannot be oversimplified. There is no way to locate this discourse to *one* kind of power relation.

Connections between the ideological, the resistant, and/or other positions of power struggles can be done and undone across various discourses, and even within the same discourse, as is illustrated in the aforementioned example. This happens because our social worlds are made up of variable and connected experiences and ways of thinking. The ways in which discourse maintains relations of domination in terms of varying degrees of ideological function must be the focus of critical analysis. The

concern in critical discourse analysis is not of making lists or simple categorisation, but rather of analysis as a tool to understand and change our world. This can be achieved by interpreting how the discourse serves to uphold existing power structures, and/or how it resists them.

The research questions with which this thesis is concerned can best be answered by using a critical discourse analysis which explores the texts in search of the power implications embedded in them. Foucauldian theory with an awareness of post-colonial theory provides the conceptual framework for conducting this analysis. Methods of critical discourse analysis for working with a body of text, as well as awareness of the levels of ideological function, provide the tools to engage in this research.

Chapter Three: A Critical Analysis of South African Governmental

Publications on HIV and AIDS

After coding the data using Parker's (2004) technique of identifying nouns, a number of discourses emerge in the analysis of the data set of Khomanani texts. Of these discourses one was most significant: the Hegemonic Discourse of Biomedicine. This main discourse was accompanied by two supporting discourses: the Discourse of Gender and the Civic Discourse. The supporting discourses are labeled as such because, although they emerge from the texts as particular discourses, they are not the foundation on which the texts are based. Unlike the biomedical discourse, which provides the actual language and terminology that make up the entire body of texts analyzed, they emerge as only supporting discourses.

All three emergent discourses have been deemed significant based on two main criteria: they were pervasive in the majority of the texts used in the data set, and they are directly linked to power relations—governmental policies; dominant or hegemonic discourses; and colonialism—in the social context in which they were produced, South Africa. This chapter describes the three discourses, shows the ways in which they can be identified, discloses their construction, and illuminates the relationships between them and the maintenance of power structures in the social context in which they emerge.

3.1 Hegemonic Biomedical Discourse

The hegemonic biomedical discourse that emerges from the text, permeates the data set. This discourse is the dominant way of writing, reading, and speaking about HIV globally and its occurrence is especially important because of its direct links to the

Western conceptualisation and construction of health and medicine (Seidel, 1993).

Nearly every page of text uses the language, images, and conceptualisations of Western hegemonic biomedicine. This is exceptionally striking in the context of the South African governmental document given the current climate of heated debate its response to HIV and AIDS seen in the discussion on denialism. In these Khomanani texts no other view of healthcare is presented. For example, there is no evidence of any resistant discourses on prevention, treatment, or care for HIV. There is no discussion that falls outside of the norm of institutionalised, standardised, and bureaucratic forms of healthcare that are associated with the Western biomedical model. Nor are there any specifically South African discourses that provide information on treatment of illness that falls outside this Western biomedical model created for the Khomanani texts. Rather, any mention of more localised South African forms of healthcare are actively devalued through brief warnings telling readers that one should, “Tell your health worker if you are taking any other treatment. This includes vitamins, any medicines you get from a chemist and traditional medicines, like the African potato. If you take them when you take ART, the treatment may not work” (Khomanani 2008c, 29). This reference to the ‘African potato’ is the only reference to any specific form of ‘traditional medicine’ in the data set. This is troubling because of the association of the ‘African potato’ as a discursive object with denialist discourse. It is also problematic that this stigmatised object is used to represent all forms of treatment or ‘medicine’ that fall outside the Western hegemonic model. Many South Africans use various non-Western medicine and treatment for illness. These responses to illness have been completely erased and denied

analysis due to the hegemony of specifically Western language and constructs of biomedicine.

Gill Seidel (1993), in research on HIV and AIDS discourses in South Africa, describes medical discourse as relatively new but one that has quickly become the only legitimate way to think and speak about HIV. Furthermore, she explains that the medical discourse has become so dominant that it has come to be identified as “neutral” and natural, beyond any debate. She writes,

[Medical discourse about HIV and AIDS in South Africa is] A very new, very authoritative and sophisticated variety of the discourse of control and exclusion, which, because of its medical scientific stable, passes as neutral and non-ideological. (Seidel 1993, 177)

This supposed ‘neutrality’ is a very important part of biomedical discourse, both because it helps to ensure biomedical hegemony and by making critiques of biomedical discourse immediately invalid. This discourse closes all debate about alternative ways to think, speak, and act in relation to HIV and AIDS. The hegemonic biomedical discourse has three main features: specific technical language, the construction of binary power roles in the form of ‘doctor’ and ‘patient,’ and a lack of any holistic framework for a response to HIV.

3.1.1 Technical Biomedical Terminology

The first feature of this discourse is the pervasive use of technical medical terminology (Seidel 1993). There are two problematic areas of this specialized terminology: its inaccessibility and the confusion it creates when inaccessible language is haphazardly combined with familiar terms in the structure of an introductory booklet or

leaflet. Biomedical terminology is the most broadly used and most acceptable way of writing, speaking, and possibly thinking about HIV and AIDS globally. In the Khomanani texts all descriptions of bodies, as well as the way in which sickness and forms of treatment are constructed, are expressed through technical medical terminology associated with Western science's conceptualisations of biology, health, and illness. For example, in the three page leaflet, *Key Points about HIV and AIDS*, the following information is presented,

AIDS is a disease that affects millions of South African. It is caused by a virus called HIV that makes it difficult for a person to fight off other diseases.

HIV is spread from one person to another

- by having unprotected sex with an infected person
- through contact with infected blood
- from a infected mother to her unborn or newborn baby. (Khomanani 2008f, 1)

Biomedical language may be unintelligible or confusing to people who have not been trained or educated in this particular language and way of thinking. The use of this language presupposes a reading audience which has already obtained a high level of health, and mainly Western health, literacy through professional medical experience and access to medical knowledge. Furthermore, it assumes that health literacy is framed by the language and ideas of Western medicine. Problems arise when the readers have little knowledge of the technical language.

The definitions of particular terms in the texts provide an example of the first problem of biomedical terminology being inaccessible or confusing to the reading audience. The first definition of "HIV" provided in many of the texts is simply "the Human Immunodeficiency Virus" (Khomanani 2008). Upon a superficial examination of the texts, this may seem like a fairly neutral explanation, the 'obvious' definition based

on ‘common sense.’ However, from a more critical perspective on the ways in which biomedical language is being used in the texts, the shortcomings of this ‘explanation’ can be viewed. Simply using the terms “human,” “immunodeficiency,” and “virus” in order to explain to someone what “HIV” *is*, actually provides quite a difficult and vague definition. In fact, it does not provide a description of the disease at all.

This definition of a very important and widely used term in the Khomanani texts does not actually explain in simple, more familiar terms—which one requires as the task of a ‘definition’—exactly what HIV is. What exactly is a “virus”? Why is it necessary to preface the kind of virus with the word “human”? Although the texts do go on to provide further definitions of HIV through descriptions of some of the various symptoms of the illness, these descriptions are also presented only through technical medical terms. For example the booklet *YOU & HIV/AIDS* says,

The Human Immuno-deficiency Virus (HIV) is a germ that gets into the body’s White Blood Cells (WBCs)...These WBCs are the cells in your body that help fight disease. When HIV gets into these cells it uses them to make copies of itself and in the process destroys them. (Khomanani 2008l, 6)

These kinds of descriptions further compound potential confusion for those who read the materials by using many new terms to describe HIV rather acting as an entry point to information on the illness. At the same time, however, it further reinforces the idea that the biomedical model is the only possible way in which to discuss HIV. HIV, according to the texts, can only be defined within the biomedical discourse which relies on the same language as the word itself.

This confusion caused by attempting to define unfamiliar terminology using that same terminology can again be seen in an example from the Khomanani booklet, *HIV and AIDS: Prevention, Care, and Treatment*. In the introductory section of that booklet

under the heading “What are HIV and AIDS?” the section begins by saying, “HIV is transmitted through blood, semen and vaginal fluids. Once in the body the virus uses the CD4 cells of the body’s immune system to replicate itself” (*HIV and AIDS: Prevention, Care, and Treatment* 2008, 5). This section of the booklet is meant to be introductory but is written with the assumption that the reading audience has knowledge of specific and technical terminology, as well as being highly health literate overall. Not only must the reader know what a cell is, they must know what a CD4 cell is and why it is an important component of the human immune system. Readers must also know what viruses, replication, and immune systems are. In addition, they must have some sense of the Western medical, non-holistic conceptualization of human bodies as systems of discrete pieces that operate like parts of a machine (Seidel 1993).

Through their use of language that is *not* introductory, these texts actually exclude people from the knowledge they are seeking about HIV and AIDS. The texts are excluding lesser educated people from the inner circle of those who can understand the information, reinforcing existing structures of power and access to resources. The hegemonic biomedical discourse in these texts creates a dividing line, through the use of technical terminology and general health literacy, between those who are better educated and more in control of their health and those who are not. And, once that line is drawn, it can create a barrier for those who are less educated about the biomedical model of disease and medicine, to find effective health care.

The problems with the Khomanani texts identified above represent a dilemma that occurs in the creation of the texts. They should not oversimplify the way in which they reach their consumers, but the use of technical language may enhance differences

between those who are 'in the know' and those who are 'ignorant.' Biomedical discourse in the texts does not empower readers by educating them on HIV, AIDS, health, and bodies from this dominant point of view. Rather, it diminish people's power by reinforcing the stratification of people into less powerful positions in the creation and transmission of information and prevents people from obtaining essential information to take positive action for their own health needs.

The second problem regarding the use of biomedical language and terms is the style of writing seen in the texts. There is a tension between the biomedical discourse and an attempt at more mainstream or accessible discourse. This is seen both in the mixture of types of language and terminology found in the texts, as well as through the style and structure of the leaflets and booklets. For example, the introductory portions of each brochure attempt to transmit a basic level of information through the use of highly technical language. In the booklet *HIV and AIDS: Prevention, Care and Treatment* in the section "What are HIV and AIDS," the introductory discussion of HIV says,

Many people think being HIV positive means you had AIDS, but HIV infection and AIDS are not the same.

HIV is the Human Immunodeficiency Virus

HIV is transmitted through blood, semen and vaginal fluids. Once in the body it replicates itself...As the amount of HIV in the body increases, the number of CD4 cells decreases, weakening the immune system every further.

AIDS is the Acquired Immune Deficiency Syndrome

AIDS is the collection of diseases that are 'acquired' from HIV once the immune system is no longer able to protect the body from illness...When a person's immune system has deteriorated so much that he or she starts becoming ill with life-threatening and often unusual illnesses, he or she is said to have AIDS. (Khomanani 2008d, 5)

These introductions, which are complexly worded, mixing the technical with the colloquial, may be even more confusing than the biomedical discourse alone. The technical terms may be essential to the ideas being expressed, but because they are used

along with familiar language, they may transmit a message entirely different from the one envisioned by the writers. For example a section in the booklet *I had an HIV test – now what?* (2008) describes steps one should take to stay as healthy as possible after receiving a positive HIV test result. The text advises a person to, “always use a condom when you have sex to protect yourself from getting infected again. If you get a new HIV infection, this will make your immune system weaker” (Khomanani 2008e, 5). The text emphasises the importance of protecting oneself from germs and viruses. It is helpful that the texts present the point that exposure to HIV, even if you are already living with the virus, is also quite harmful. (Smith, Richman, and Little 2005) However, problems can arise when complex health information is presented in a casual way. What does the text mean when it says “a *new* HIV infection”? This could suggest that one would only be exposed to a “*new* HIV infection” by having sex with a *new* person, when this is not the case. The reading audience may believe that they can continue to have unprotected sex with an existing partner because this is not a *new* partner. However, having sex with anyone without the use of condoms, exposes a person to myriad viruses and bacteria and is especially taxing on the already compromised immune systems of people living with HIV. People living with HIV who are repeatedly exposed to HIV, whether from a ‘new’ or ‘familiar’ partner add to the load (amount) of HI virus in their bodies, moving the infection along at a faster pace (Smith, Richman, and Little 2005). This section of the text seems to present some important ideas, in passing, about ways to maintain health, which, instead of reinforcing healthy behaviours, may actually reinforce unhealthy behaviours because of a lack of clarity.

The text's structure as a series of booklets and pamphlets that comprise a complete set is another area of tension and confusion between biomedical and more casual language and constructions. The set is to be read in a particular order such that each subsequent booklet or pamphlet builds on the concepts presented in the preceding one. The structure of the texts is generally a basic or introductory one. For, example, they frame the information as question and answer. In addition, all of the statements are short, direct and use seemingly simple unsophisticated descriptions. These introductory portions also evoke colourful and widely recognized imagery, such as comparing an immune system to an army. The level of health literacy necessary to interpret the information successfully, however, is not basic. Consider the following discussion,

Do you know what HIV and AIDS is?

Quite simply this is what happens:

A healthy person's body has a natural system (immune system) that defends the body every moment of every day from thousands of disease germs, infection and viruses that, if not stopped by this immune system, can be potentially very harmful to you.

The White Blood Cells (WBCs) in your body make up this natural immune or defence system and fights off disease germs. It is like an army defending a country (your body) against invasions.

HIV is a fierce germ that attacks this immune system and over time eventually begins to weaken and destroy it. A person when infected by HIV is described as being HIV positive. At this stage they may look and feel healthy.

When WBCs destroyed by the HIV virus cannot be replaced fast enough, the body can now be easily affected by other, potentially harmful germs, infections and viruses (e.g. TB, pneumonia, etc.).

When these infections take hold, the person is now described as having AIDS or having an AIDS related condition or infection.
(Khomani 2008, 4)

On first glance, the section quoted above may appear to be presenting clear, concise information at an elementary level. However, the content of the information is

actually less accessible than its initial appearance. Contrasting the opening question, “Do you know what HIV and AIDS is?,” with a question from an earlier booklet, “What are HIV and AIDS?,” (Khomanani 2008d, 5) is an area of complexity and potential confusion can be seen. This difference in wording stands out because of debate that surrounds the way in which HIV and AIDS are defined respectively, as well as how HIV and AIDS are connected to one another. The differentiation between HIV and AIDS, for example, is something that has been quite variably defined. In previous years this differentiation was made by TCell counts, or through the identification of ‘AIDS-related’ or ‘AIDS-defining’ illnesses. (Treichler 1991) Currently this debate is connected with denialist discourses or anti-stigma campaigns. They either challenge the connection between HIV and AIDS for sociopolitical reasons, or in order to destigmatise the experience of HIV by changing the language used to describe it.

The problem of definition is not one of merely complex medical terminology or levels of ability in understanding descriptions of virology. There is a history of stigma attached to the terms HIV and AIDS. In South Africa there exists a heated debate surrounding the question of whether and how HIV and AIDS are related. Some political leaders have suggested that AIDS is not a result of being infected with HIV (Butler 2007). AIDS activists have strongly criticised this denialist position and argue that it misleads people into thinking that if they have been exposed to HIV, they need not necessarily be concerned about illness as a result of AIDS or in taking anti-retrovirals to prevent AIDS or other illnesses from occurring. Forming the question with “is” (“Do you know what HIV and AIDS is?”) implies HIV and AIDS are the same thing. This could be an attempt at avoiding the controversy of the denialist discourse in South Africa,

where, if HIV and AIDS are presented as too separate, then it may be unclear whether they are, in fact, related at all. A way of destigmatising illness is to take away the mystery associated with sickness, pain, and death. This is accomplished when people have been educated about an illness such as HIV through very clear and easily understood descriptions and explanations. For example, presenting the fact that HIV is not the same as AIDS, and that HIV is the name of a virus, whereas AIDS is a specific set of symptoms caused by this virus that make up a syndrome which causes the body to function in “abnormal” or unhealthy ways. (Fauci et al 2008) The way that the texts construct the question (“Do you know what HIV and AIDS is?”), inextricably uniting the two terms, is incorrect. Defining HIV and AIDS as separate yet interconnected, strengthens the argument that people who are HIV positive should actively seek treatment and social support so that they can hinder the onset of AIDS. Making the two appear identical is confusing, misleading, and potentially harmful if it prevents people from taking action on behalf of their own health. (King 2002)

After the discussion of “HIV” and “AIDS,” the text identifies “disease germs,” “infections,” and “viruses” as “potentially very harmful to you” without complete explanations of the terminology (Khomanani 2008l, 4). “Disease germs” is a problematic phrase. If the reader finds definitions outside of the Khomanani text, the phrase may still be unclear, because in wording “germs” with the adjectival “disease,” it could be inferred that the “disease germs” are very different from some other sort of germs. Here again we see how medical language becomes a way in which access to information and healthcare is kept shrouded in mystery and confusion.

The use of language and structure which present themselves as introductory reflects a tension between the need for basic information and the stigma of creating texts outside the hegemonic biomedical discourse. The supposed 'neutrality' and 'prestige' of scientific or biomedical language makes it nearly impossible to think, write, speak, or act outside of this discourse. The power of the discourse is so great it excludes or at least diminishes any alternative way of thinking or speaking about HIV. Anyone who wants to teach or learn about HIV finds they must use the biomedical discourse as a means of communication, but this particular discourse functions to maintain the status quo within the global power structure. It privileges those who are familiar with the discourse and the language. It also privileges those in broader political structures who benefit from the maintenance of the status quo.

3.1.2 Construction of Binary 'South African Patient' and 'Western Doctor'

The second feature of the hegemonic biomedical discourse is the construction of a 'patient' and a 'doctor,' or specifically for Khomanani, a "health worker." These discursive objects are constructed through the discourse with specific identities, expectations, and responsibilities. The creation of these binary objects of 'health worker' and patient' through the texts directly links to identity and responsibility in terms of agency and access to power (Foucault 1972, 41). There are also specific connotations owing to the South African context. The South African 'patient' is positioned as a localised citizen and the 'health worker,' who advises from a strictly Western hegemonic position, speaks as a representative of the global dominators, in the terminology of biomedicine.

The way that this polemic relationship is constructed in the texts is by creating a 'patient' who seeks knowledge from an omnipotent 'health worker.' The advice of these 'health workers,' in the form of doctors, nursing sisters, and counsellors must be listened to and adhered to. For example the many references to and descriptions of the 'patient/health worker' relationship in the booklet *Anti-retroviral treatment for life!* Readers are introduced to "The team of health workers" and told that, "when you start ART there will be a team of people who will look after you. We call the people in this team, health workers" (Khomanani 2008a, 9). Later on in that booklet interaction between 'patients' and health workers is briefly elaborated on by telling readers to, "answer all questions truthfully. Your health worker will then know all the facts and problems you may have about sticking to your treatment" (Khomanani 2008a, 24). The health worker's position is one of power. As the booklet describes how they "will then know all the facts and problems" as the 'patient' divulges information about their life and experience with HIV, it is strengthening the structure of power in this unequal relationship. Most importantly, however, is that the fact that a power dynamic between a 'health worker' and a 'patient' exists can be attributed to the hegemonic biomedical discourse in the form of the Western conceptualisation of prevention, treatment, and care. This is what health workers have been trained in and are expected to promote. For example in the section "How will I know if the ARVs are working for me?" readers are told that,

A health worker will check whether the ARV medicines are working well for you by doing:

- A CD4 count...
- A viral load test...
- An examination. A health worker will examine you to check your weight and to see if there are any changes in your body and your health. (Khomanani 2008a, 15)

This section shows readers that the health worker alone will be able to evaluate whether or not treatment is “working” for a person. They will do this through the use of complicated medical tests that require equipment for and training in the use of Western pharmaceuticals. A key situation illustrating the ‘patient/doctor’ relation is in the use of prescribed Western medications.

Prescribed medicines and medical procedures in the form of Western pharmaceuticals, mainly ART and blood tests, are presented by the Khomanani booklets and leaflets as the only necessary and valid ways of addressing and treating illness caused by HIV. To be clear, anti-retroviral treatment has been successful in treating HIV and allowing people to live longer, more productive, and more hopeful lives. This form of treatment being singled out as *the* specific isolated means of treating HIV and AIDS for South African people is problematic.

The debate surrounding access to ARVs has been sizeable in South Africa and around the world. This debate provides an example of an important problem with Khomanani’s reproduction and reinforcement of the hegemonic biomedical discourse in its construction of ‘treatment’: the forms and conceptualisations of treatment from the hegemonic biomedical discourse—which is centred in Western constructions of health and medicine—cannot be relevant to all geographic locations and all people. Without oversimplifying this debate, it can be stated that unequal access to power and money are the main barriers for people in securing these medicines. In the case of the data set of Khomanani governmental texts, ART is correctly identified as being the most successful means of treating HIV currently. It is indeed a paradox that the South African state is

providing the funding and the means to produce and distribute these booklets and leaflets about ART, and at the same time, the actual state infrastructure to provide this kind of treatment for South African citizens falls far behind demand (Medecins Sans Frontieres 2008). In this way, the texts provide an advertisement for South African governmental ART which exists in statute, but is not yet available to all people. The reason for this is that the discourse streaming through this channel of power, the health worker as constructed in the texts and the texts themselves, is that of hegemonic biomedicine. The texts reflect the only 'acceptable' means of addressing HIV and AIDS, rather than ways that are in fact necessarily feasible or 'acceptable' to the South African government itself.

3.1.3 Un-holistic Response to HIV

A third feature of the hegemonic biomedical view of HIV, is the abstraction of people from their social environment, or an un-holistic response to HIV. All aspects of the experience of living with HIV other than those directly ascribed to the biomedical sphere are either undermined or erased. Western biomedicine constructs people as separate from their social context. Indeed, they learn to view systems within an individual's bodies as quite separate from each other. According to the Western healthcare model, one must see a cardiologist for the heart, a gynecologist for the uterus, and a neurologist for the brain. This point of view creates a problem in regard to HIV and AIDS as a health issue because it addresses HIV and AIDS as *only* that. None of the human, social, economic, or political aspects of HIV and AIDS are taken into consideration in the texts.

Thus, the 'patient' is removed from their personhoods and the contexts in which they live. These parts of human lives are, in fact, both undermined in terms of their importance or effect on people and their experiences of HIV and AIDS and made completely invisible. The biomedical discourse assumes that, if a scientifically created treatment has been developed, then all a person needs to do to access care is to become knowledgeable about the treatment and use it. As the texts leave out information about living with HIV the documents become impractical at best, and, at worst, reinforce differences between: those who are ill and those who are not; those who are a 'patient' and those who are a person; and those who have access to treatment and those who do not. Seidel argues that, "medical discourse is concerned with symptoms, with depersonalized 'seropositives'...Medical discourse has shaped the cultural agenda of AIDS in which the Person with AIDS, as a full human person, is absent" (Seidel 1993, 176).

As part of this constructed absence of the "full human person," the social and political context that may or may not allow a person to access the treatment is ignored as an issue beyond the realm of science and medicine. Hegemonic biomedical discourse attempts to depoliticise health care by ignoring the sociopolitical forces surrounding it.

Another example of this unholistic and dehumanising way of conceptualising healthcare is again visible in the case of ART in the texts and in South Africa. ARVs are not simple medications to take. In our society they require a network of people and careful planning in order for an individual to take them successfully. ARVs must be taken everyday at the same time for the rest of a person's life. Adherence to ARVs and success in living a healthy life with HIV requires a person to have access to proper

support from medical facilities in order to be able to get the medication consistently and on time. It also requires a person to be able to eat regular nutritious meals including fruit, vegetables, protein, and clean water. In addition to meeting physical needs, people who are taking ARVs must also have social, emotional, or familial support.

Living with a serious illness is difficult enough but combined with HIV stigma, morbid images of AIDS, and grueling ART regimens, it can be overwhelming. Individuals, alone, cannot usually cope with these pressures and are often ostracised by otherwise close knit communities, families, and neighborhoods. As the Khomanani documents inform readers of the aspects of ART other than pharmaceuticals, they do so by placing emphasis on the individual's responsibility for accessing these necessary treatments. In this way it becomes the individual's negligence if they cannot properly access and organize their own treatment.

In South Africa particular constructions and experiences of race, class, language, and geographic location exist due to colonialism, apartheid, and post-apartheid states. These structures have left many people in positions where the necessary parts of ART, besides the ARVs themselves, are nearly impossible to access. Such a strong focus on information regarding ART is strange in relation to the ongoing debates and denialist discourse on the relevance of and access to ARVs in South Africa. It is also paradoxical that the infrastructure, management, and funds necessary for the governmental provision of ARVs do not exist, yet readers of these governmental publications are told repetitively that this is the treatment to be sought after and "adhered" to. The texts present a situation in which the reader is shown that the only 'true' means of treating their illness is through a regimen of a combination of pharmaceuticals; regular visits to a state healthcare facility

to discuss intimate details of their lives with state health workers; and obtaining a diet which is outside the means of most people living in South Africa. The leaflet, *Living with HIV and AIDS* (Khomanani 2008g) summarizes how “you can lead a healthy life” by doing key things listed under the following headings: “Practice safer sex;” “Take care of you health;” “Eat healthily to help your body fight diseases;” “Have a positive attitude;” and “Get support” (Khomanani 2008g, 1-3). The leaflet gives various descriptions of how a person “infected with HIV” should:

- Eat a varied and healthy diet.
 - Only take medicines given by health workers.
 - Look at the positive side of things.
 - Find out more about services that offer HIV and AIDS support in your area...Information and Counselling Centres are in most big towns.
- (Khomanani 2008g, 1-4)

If the Khomanani texts only provide the prescription of eating well, caring for one’s health, and taking one’s medicine as treatment for HIV, without suggesting how the larger political and social structures must be addressed to allow a person to take these actions, the texts limit people’s access to better health rather than facilitating it. An explanation for this limiting effect of the texts may be that, as the biomedical discourse presents HIV in this medicalised and intellectualised way, HIV can become impersonal, relegated to the realm of papers, texts, and lab work, rather than to community interdependence. Both the humanity and the politics of the situation of HIV in South Africa are made invisible.

The discourse of hegemonic biomedicine, with its technical terminology; objects of ‘patient’ and ‘health worker;’ advised forms of both behaviour and treatment; its conceptualisation of human bodies as a sum of parts; and presentation of individual humans as separate from their social and political context is present in the texts because it

is the hegemonic—most respected and accepted—way of conceptualising; writing about; and discussing HIV and AIDS in the ‘Official’ domain. The official governmental body which is funding and publishing these texts is doing so within the hegemonic biomedical discourse and under the gaze of various powerful groups both nationally and internationally. The use of language, terms, or concepts that are not those of the prestigious and powerful will reflect as ignorance on their part rather than an attempt to appeal to the majority of the reading audience, or simply to offer another perspective and discourse. More care to the ways that discourses are recreated and reinforced needs to be given during the planning and creation of the Khomanani texts to avoid the kind of paradoxical information we have seen here. Who is the intended audience of these texts as they are being planned and produced? Who is the actual audience once the texts have been produced and distributed? Are these the same people? What is the ultimate contribution made by the texts on people’s health? Does it show them a realistic way to improve their health? Or does it prevent people from seeing the larger political context of what is making them sick and preventing them from practically caring for their health needs? Carelessness in identifying and purposely avoiding problematic discourses such as the biomedical one, even if the creators have good intentions, can lead to oppressive or disempowering effects as we will see replicated in the discussion on gender discourse.

3.2 Gender Discourse

A second discourse that emerged in the Khomanani texts was one of gender. This discourse constructs normalised, patriarchal gender expectations, and relationships. The gender discourse identifies different roles and responsibilities for men and women in

relationships making women most responsible for risks in sexual relationships.

Furthermore, it places the burden of care and familial responsibility regarding HIV and AIDS on women (Kleintjies et al 2005). The appearance of this discourse is troubling as it seems that it is being recreated as a direct result of efforts to actually empower women through the texts (Tallis and Cavanagh 2004).

An emphasis on women's connections to HIV and AIDS is made by addressing women more specifically than men. This can be seen in the titles, headings, section, topics, and themes identified in the texts themselves. The booklet *HIV and AIDS: Prevention, Care and Treatment* identifies and addresses the topic of "Gender" (Khomanani 2008d). The subheadings under this topic include:

- Why are women physically more vulnerable to HIV than men?
- What are the socio-economic factors that place women at risk?
- What about men who have sex with men (gay, bisexual and homosexual men)? (Khomanani 2008d)

It is essential to address the fact that women are being infected with HIV at higher rates than men. It is also important that the texts seem to address both the socio-economic and the physical reasons for women's increased vulnerability to HIV as they present information on gender in relation to HIV and AIDS. However, this cannot be done in a simplified manner, merely in headings and small subsections, or with insufficient analysis of gender discourse.

There are three main features of gender discourse that can be identified: women being singled out by address, the absence of men's roles and responsibilities, and the construction of women as 'mothers,' or caregivers. The first feature of this discourse is the way in which women are addressed and singled out. Throughout the texts, the words "person" or "people"—terms which are gender neutral—are used as a means to address

the generic reading audience. Women, however, are selected out as the ‘other’ and addressed more specifically in relation to describing their particular duties, as in the examples of descriptions of the use of female condoms. Out of the entire body of texts, there are only two small sections on the use of female condoms in the *Anti-retroviral treatment for life!* and *HIV and AIDS and Treatment* booklets. Both of these booklets inform about the use of condoms, stating, “[female condoms] these are condoms that can be used by women...It is not easy to get these condoms, and they are not free. Find out from your clinic if female condoms are available in your area” (Khomanani 2008a, 31; 2008c, 8). Although this provides a brief introduction to female condoms, it presents a dismal outlook on accessing these condoms for most women, and provides *no* description as to how the “female” condoms actually work. ‘Male,’ or ‘normal,’ condoms on the other hand are generally named simply as “condoms,” rather than with a gendered identifier. They are also described and their use is explained, or at least mentioned, in most of the Khomanani texts. This differentiation between shapes and styles of prophylactics based on gender is problematic because, by identifying condoms as “female” or “male” rather than as external or internal, for example, inherently creates the ‘female,’ or currently less popular, more expensive, and less accessible condom, as the ‘other.’ This othering relates directly to women’s disempowerment in condom usage. The texts provide detailed instructions on “male” condoms, telling readers to,

Use a new condom each time you have sex. Just before you enter your partner put the condom onto your hard penis...Roll the condom down over your penis...Now you are ready to enter your partner...Take your penis out after you have had sex...Now carefully take the condom off your penis... (Khomanani 2008c, 9)

These instructions are only given from the perspective of the man providing the condom; putting it on properly by himself; using it during sex successfully; and taking it off himself. Women are thus positioned on the sidelines of condom usage, or relegated to the use of these “female” condoms that are “not easy to get,” and “not free.”

The second feature of gender discourse is the constructed absence of men’s roles and responsibilities. In addition to othering through condom differentiation, women are made central in discussions of reproduction. The central role of women in human reproduction as constructed in the texts, takes place through an absence of information on, and for, men, as well as through repetitive emphasis on activities that have been constructed as ‘women’s.’ Reproduction is made central when specifically addressing women with many sections in the texts on pregnancy and breastfeeding, with no reference to men. Although it could be argued that these are areas where women must be singled out and particularly addressed, to do so in the absence of an equal focus on men’s particular responsibilities through areas of text in the Khomanani campaign is counterproductive to women’s empowerment.

Leaving men out is also dangerous and limits the positive health effects of the information. For example, men are an important party in both the reproduction of children and the spread of HIV. Deciding whether to have children is not women’s decision alone. Carrying a pregnancy to term, delivering a child, and breastfeeding are all tasks that can only be accomplished by females, but they are not done without men’s involvement. Men, too, have a stake and a responsibility in pregnancy, birth, and breastfeeding.

The second feature of gender discourse can be seen in the way that men are rarely addressed specifically in the texts, and that their particular duties are not often outlined or emphasised. The texts seem to assume men would already be addressed sufficiently in the gender neutral areas as they are created as the default through this discourse. And in the descriptions of reproduction, the implication is that men are only involved through conception. Khomanani states that “HIV is everyone’s problem,” (Khomanani 2008m) but the gender discourse implies that HIV is really women’s problem because of their ‘peculiar’—outside the norm which has been constructed as male—physical and social responsibilities (Fasold 1991). The only place where men are singled out is in regard to same-sex sexual relationships. Here, women, in particular, lesbians, become invisible. Instead, heterosexual women sex workers are grouped together with gay men as a special category in relation to the gendered discourse on HIV and AIDS (Treichler 1999).

Only groups of men who have been feminised in hegemonic discourse on gender—such as gay or bisexual men—are identified and addressed in their particular experience of, or responsibility for HIV. This provides an example of an interesting link between gender discourse and other hegemonic discourses on HIV and AIDS, where gay men and heterosexual women who are defined as sex workers were, and continue to be to a large extent, grouped together and blamed for the spread of the illness (Treichler 1999). By linking women sex workers and gay men together and emphasising their responsibilities in the Khomanani texts, this discourse reinforces this notion of feminised blame. It also reinforces dehumanising stereotypes of women sex workers as something apart from ‘normal’ women. In addition, it erases lesbians from the picture. Furthermore, it emphasizes the stigma associated with men who have sex with men as a

peculiar high risk group, thus reinforcing the incorrect view that HIV is a problem for 'certain kinds of people.'

The third feature of gender discourse is the constructed role of women as 'mothers,' as well as caregivers in a more generalised sense. Care work is another critical area where gender analysis is ignored yet plays a central role. Nowhere in any text in the data set in its entirety—except briefly in a more generalised way in the booklet *Talking about sexually transmitted infections* (2008k, 22-23)—are men spoken to directly about their roles and responsibilities in preventing HIV and caring for people living with the illness, either in regards to their own lives or the lives of women around them. The central feature of this gender discourse tying care work to women, is the construction of women's identity as 'mothers.' This is done repetitively through booklets, leaflets, and section headings dedicated to reproduction, babies, and children which are explicitly addressed toward women. The texts identify pregnancy, the health of babies, and ways to deal with children in relation to HIV many times. Mothers are created and represented through women's expectations in regards to reproduction and pregnancy, as well as through women's role as caregivers for children. The prevalence of topics on pregnancy, babies, and children in relation to HIV is most likely attributed to the huge problems facing South African people and the government in dealing with controversy surrounding access to nevirapine (the drug used by women who are living with HIV during pregnancy to protect their babies from exposure to HIV) and the high numbers of children who have been left vulnerable or without parents and guardians as a result of family members dying as a result of HIV (Hasan 2007; Setswe and Skinner 2008). Again, the problem in this gendered discourse is that women—as opposed to men and women, or government as a

body—are being singled out as those who are responsible to provide the care needed to address such problems.

Women's 'special' responsibilities regarding HIV and reproduction are highlighted in topic headings, as well as specific titles of the booklets and leaflets of the Khomanani data set. Women's specific and seemingly isolated reproductive role is presented in:

- *Pregnancy and HIV – what you should know*
- *Pregnancy and HIV*
- I have tested positive and am pregnant – what should I know? (Khomanani 2008d, 43)
- Pregnancy and ART (Khomanani 2008a, 36)
- HIV-positive women and pregnancy (Khomanani 2008c, 36)
- Babies and HIV (Khomanani 2008c, 38)

In all the sections of text named above, there is no mention of men's roles in either decisions regarding pregnancy or in reference to responsibility for any care required for the woman, the fetus, or the newborn baby. It could be empowering in some ways for women to have complete control over decisions regarding reproduction and their access to information specifically regarding women. However, it is actually quite disempowering in the context of the 'real' or material world when this information is presented in the absence of, or complete separation from, information regarding men in connection to these experiences. Men play inextricable roles in women's abilities to have children; their risk of getting HIV while pregnant; and their ability to provide time and money in order to care for an infant. These gender expectations must also be addressed so that women's 'empowerment' does not equate with men's freedom from responsibility to, or from connection with, the human reproductive process.

In addition to caring for themselves and their infants, women must also provide necessary care for children, men, and the greater community as well. One particular irony of this role is the responsibility of caring for other people as a result of one's own HIV positive test result. In the Khomanani texts, women who receive a positive HIV test result are then advised about the new responsibilities associated with living with HIV.

Examples of this are found in the headings:

- How to tell children you have an HIV positive test result
- Planning who will care for children if their parents die
- Health and virus prevention during pregnancy (*HIV and AIDS and Treatment* 2008c, 2)

These particular sections do not explicitly refer only to women by addressing them specifically, however, the topics and words used, such as “motherhood,” “pregnancy,” “breastfeeding,” and “care” imply that these are women's tasks and reveal the gendered nature of the discourse.

It is likely that Khomanani texts are constructed in this way as an attempt at gender mainstreaming or women's empowerment. But the intention of transferring power to women has the reverse effect when information is given in this separate but unequal way. The texts give women information about how to take ARVs; what to know about pregnancy while living with HIV; and how to feed infants properly in order to protect them from illness. The texts however, do not give detailed information to men about their roles and responsibilities in the prevention of HIV and care for people living with HIV. Women are given these jobs while men are not held responsible. They have been made invisible, to a large degree, through the gender discourse in these texts.

Ironically, this occurs at the same time at which in reality, men's socially constructed

identities and relationships with women have been identified as among the most serious, and many times the central, problematic area in the realm of HIV prevention and care (Bujra 2002).

As we saw in the discussion of Khomanani's reliance on the Western biomedical discourse, the producers of the Khomanani text may have intended to create documents that empower their readers. The texts fall short, however, because the discourse of gender results in an exacerbation of the distinction between genders. And it reinforces stereotyped and stigmatising views of men and women: men are dangerous when they have sex with men; women who have sex with other women are invisible; and motherhood is made central for women as a whole. Women, as they are constructed through gender discourse, are made solely responsible for reproduction and care work, while men are excluded from these activities.

This section shows how discourse serves to construct people's identities around various created roles, responsibilities, and interactions. Those roles, responsibilities and interactions are asserting and reinforcing relationships and structures of power that place women in a subordinate position. In the next section we will see the roles and responsibilities constructed around civic identity, where the interactions take place between people and the state.

3.3 Civic Discourse

The civic discourse is the third identifiable discourse that emerged in the Khomanani texts reviewed in this analysis. Government is an institution and part of the larger infrastructure that makes up the 'state.' This discourse constructs the role of

government and the relationship of people, as citizens, with the government. The government is identified as the authoritative and ultimately responsible party regarding health issues such as HIV. It also identifies individuals as subjects of that government and necessarily dependent on it for any hope of avoiding becoming ill with HIV or in hindering the health problems created by HIV.

Two specific features identify this discourse. The first is the construction of another set of binary identities which serve to recreate and reinforce dominant power structures, similar to the 'patient' and 'doctor' of biomedical discourse, but this time in the form of 'citizen and 'government.' The second feature of civic discourse is the creation of a mythical welfare provision which supposedly 'provides' sufficient grants and resources without actually having to give them.

The first feature is illustrated in the texts, which say, "the government believes that it needs to look after people who cannot look after themselves, especially children. A grant is money that is given by the government" (Khomanani 2008c, 44)" and that, "people have the right to social security. The government has grants available to help care for children and for very sick people" (Khomanani 2008b, 3).

This discourse creates the 'citizen' as someone who has only to seek the proper health worker, clinic, and grant in order to access all the resources they need and deserve. It also portrays the government as benevolent: it "needs to look after people," it "gives" to people," it "helps care for sick people." At the same time, it portrays citizens as vulnerable, needy, and at least a little incompetent—like 'children,' "who cannot look after themselves."

The government is not portrayed as a sum or appendage of the people themselves. Nor are 'citizens' portrayed as people who can use their government as a tool, and make their own decisions. The funds for developing the Khomanani materials, of course, come from the citizens, but the documents do not present the government as a function of the people, the tax payers, the citizens of the state. Rather, the government is presented as a powerful institution that is quite separate from its citizens and looks down on them to help them by providing resources: medical, informative, and monetary.

The second feature of the civic discourse is illustrated by an absence of discussion in the texts of the limits of government resources. The texts describe the services 'available' as if the citizen need only ask the government for assistance. The texts tell us that "different kinds of grants," are 'provided' by government in relation to HIV and AIDS:

- The Child Support Grant
- The Care Dependency Grant
- The Foster Care Grant
- The Disability Grant (Khomanani 2008c, 44)

The texts do not, however, tell the reader how difficult, or perhaps impossible it is to obtain the grants and services. The discourse ignores the fact that these grants are often nearly impossible to obtain and to keep. The Khomanani texts give citizens a list of what they need to provide in order to access these government provided grants. For example, in the section "Government grants" in *HIV and AIDS and Treatment* (Khomanani 2008, 44), the list says that,

When you apply for a grant, you need to take these things:

- A bar-coded South African identity document.
- Proof of your income if you are employed...If you are not employed, you need an affidavit to prove that you don't have an income.
- Your marriage certificate or divorce order...

- A birth certificate for the child you are applying for. This must have a 13-digit identity number.
- A death certificate if one or both of the child's parents are dead.
- For the Disability Grant, you may need a letter from your doctor saying you are too sick to work. (Khomanani 2008c, 45)

This seems to be a comprehensive list of all the things necessary for a person to access resources and money from the government. In actuality it involves complex government bureaucracy, with no guarantee of success. Also, individual responsibility of the citizen to gain access to these resources is created, rather than responsibility of the government to provide the resources to citizens. The discourse, then, constructs the relationship and roles of government and citizens in a way that defends existing state power structures by simultaneously portraying the government as benevolent and effective and citizens as needy but unable to help themselves. Fairclough has considered this binary construction which serves to maintain structures of state dominance more generally. He argues that this kind of discourse works well not only to construct this relationship and to support the maintenance of the status quo, but also to keep citizens from seeing the full political picture. It makes the political inequality invisible and therefore beyond criticism. He writes,

The ideological role of implicit assumptions...is in providing a commonsensical framework and procedure for treating...social problems...in a purely individual way...This is 'common sense sustaining unequal relations of power' in the sense that it helps deflect attention away from an idea which could lead to power relations being questioned and challenged – that there are social causes and social remedies, for social problems. (Fairclough 1989, 84)

The way in which the texts represent government grants as something which citizens must seek out by themselves and work to access by providing the necessary time and documentation to various government offices has additional implications which

Fairclough notes in his reference to “social problems,” “social causes,” and “social remedies.” The discourse shifts responsibility for “social problems” from large social structures such as the state to that of the individual. An individual, however, cannot be responsible for addressing an institutional social problem alone. If it were true that a few individuals were unable or unwilling to take responsibility for their health while the government provided assistance by making resources available to them, this might be considered an individual problem with an individual solution. There are millions of people, however, who are unable to access the services they need to prevent HIV and to care for people who are HIV positive.

Not only are the services non-existent or inadequate, they may also be unknown. Wading through all of the government’s documents for information about what services are available, or should be available, is a monumental task. The texts, however, appear to assume that the citizen has access to the tools necessary to find out what policies have been enacted and what services are in place. In order to access these governmental resources, these necessary tools would include being able to find and obtain many official documents; having access to money and a vehicle for transportation to and from various governmental offices; knowing their rights and law; understanding legal language; being literate; and in most cases being at least bilingual, since South Africa is a multilingual society with documents written in as many as 11 official languages. This is another vicious cycle in the discourse as the citizens must *have access* to resources in order to *gain access* to these same kinds of resources from governmental departments. Governments, thus, keep control over their citizens without ever having to reciprocate this relationship with the provision of resources and services.

Why do the documents describe so many services that are unavailable or nearly unavailable? Critical discourse analysis seeks to identify what power structures are being supported or critiqued by the ways in which discourse occurs. Discourse includes not only what is said, but also what is not said. In this case the discourse in the Khomanani texts tells us that the government has approved a wide array of services for citizens in regard to HIV. The discourse does not tell us that the funds and infrastructure for these services is not available or not adequate to the task. There is no resistant or alternative discourse which would give more realistic, valuable information to the reader. This problem is currently a central political issue in South Africa. Citizens are given lists of services, plans, and programmes on various aspects of their lives by government, and rarely receive these kinds of services and structured access to resources.

This feature of civic discourse which uses the omission of particular problems in its constructed role of 'government' and 'citizen' as a means of presenting a mythical social services programme helps to maintain the existing power structure in two ways. First, it legitimates the system by making it appear that the government is serving people. Second, it saves money by not actually providing the service which allows the government to either accumulate wealth, thereby increasing its power, or providing it with more funds to spend on other needs that enhance the perception that it is effective (Aulette 2007). The problem of course is that at some point the bill will come due. People will begin either to question the validity of the argument that the services are available or they will demand that the services are in fact made available. In relation to HIV and AIDS service provision there are fatal consequences. There has already been

much discussion of the economic and structural impact of the deaths of so many young people in South Africa as a result of HIV and AIDS.

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Chapter Four: Conclusion

Through the critical discourse analysis three main discourses emerged: hegemonic biomedical discourse, gender discourse, and civic discourse. These discourses all served to recreate and reinforce existing oppressive global and national power structures. The first, the Hegemonic Biomedical Discourse, supports the power differential between Western biomedical professionals and people outside that circle. At the same time it enhances the political hegemony of Western over Non-Western; biomedical professionals over non-professionals; and the government (which is allying itself with these authorities) over the governed.

The second discourse is focused on gender. Here the discourse places women at the centre of attention. Ironically this special treatment does not privilege women. Rather, it subjects women to men and children as the responsible party and the caregivers for people who are affected by and living with HIV.

The third discourse centres on the government. The Civic Discourse bolsters the power of government over citizens. In this discourse, what goes unsaid is at least as important as what is said. The civic discourse tells us that citizens need a government to help them and that the South African government is serving their needs. But that discourse runs counter to the reality where many of the services, infrastructure and resources that are necessary to eradicate HIV and to care for people living with HIV are not available.

Another feature of these interacting discourses is the invisibility of any evidence of resistant discourses from the texts. The political debates regarding HIV in South Africa are widespread and forceful. Public demonstrations take place constantly; the

Parliament engages in debate and policy development; the media reports issues surrounding HIV daily; and every social institution is touched by discussions of HIV. The erasure of resistant discourse in the Khomanani texts, therefore, is particularly remarkable. The creation of these texts took place among people who are undoubtedly highly aware of competing or resistant discourses. These tensions must have been present in the minds of those people and groups creating the Khomanani texts, as they were specifically awarded government tenders to do work on HIV and AIDS media in South Africa. But these tensions, either in description, or through detailed analysis, do not appear in the literature they have created.

People or institutions who work to create texts and bodies of knowledge in a positive and useful way must be conscious of both dominant and resistant discourse. Even if they are intentionally and vigilantly seeking to resist dominant hegemonic discourses, these discourses will be present unless they are fully disclosed and acknowledged. The power of dominant discourse is its appearance of neutrality and naturalness. Dominant discourse appears as if it were *the* only way to think and speak about an issue. Only a methodical critical discourse analysis can uncover its full meaning and implications.

This is a troublesome finding for South Africa. One might expect more from this particular government, because of South Africa's role as a new democracy with one of the most progressive and egalitarian constitutions in the world, and because of the huge impact HIV and AIDS have had, and continue to have on the population, economy, social structure, and *lives* of its citizens. This finding of a marked absence of resistant or new discourses on HIV and AIDS, however, is one that is not completely surprising due to

existing global struggles of discourse, culture, and power, whose presence is very visible in the context of South Africa's experience with HIV and AIDS. South Africa's government's location and role in the world is a complex one. It is deeply entangled with struggles between Africa and the West; Africa and a history of abuse by Western medicine; South Africa and interaction with African countries; and the struggles between the state and the people of South Africa themselves.

The history of HIV and AIDS in South Africa is a culmination of the histories of colonialism; tropical medicine; the creation of the 'Other;' racism; capitalism; slavery; exploitation; abuse of African countries by Western pharmaceutical companies as huge money making industries; the use of African human bodies as locations for medical and societal experiments; apartheid; poverty; industry based on migrant work done by people separated from their families; and patriarchal and misogynistic social norms. This does not, however, mean that South Africans are to be thought of as simply as an oppressed group of victimised people. This is only half the story. The South African history of HIV and AIDS is also a history of mass organised resistance movements; breakthroughs in destigmatising HIV and AIDS in communities; and gaining access to treatment that has saved, and continues to save the lives of tens of thousands of people. These histories create the complex context in which the texts of the Khomanani: Caring Together Programme take place. As it is the responsibility of government to provide a response to the problems its citizens experience, these governmentally planned, produced and distributed texts seek to, "reduce the new HIV infections and increase treatment, care, support for those infected and affected by HIV and AIDS" (Khomanani 2008m). Great care should, then, be taken to create a media campaign which does not reinforce or

become a part of the oppressive and exploitative history. Rather, these new texts should join the South African resistance story. This is a task of immeasurable difficulty, but a task that is achievable with a particular plan and enactment.

One way to begin this plan and enactment to successfully address HIV and AIDS, through texts, media campaigns, and other responses, for the people of South Africa is through a concerned and critical evaluation and unpacking of the denialist and hegemonic discourses that taint these texts. Part of what is happening in these texts is a simultaneous rejection of, and immersion in, Western and exploitative dominance and discourse. This discourse of denialism is important to an analysis of government discourse in South Africa on HIV and AIDS. It is important because of its relation to access to treatment; reproduction of oppressive state power structures in texts; and its hegemonic rejection of resistant discourses from other South African people and groups. The examination of this interaction between denialist and hegemonic discourses is a necessity as this struggle stands as an explicit example of South Africa's liminal position between Africa and the West; between a 'true' 'original' 'African' discourse and one that has been molded to, and by, the Western World. V.Y. Mudimbe asserts that,

Marginality designates the intermediate space between the so-called African tradition and the projected modernity of colonialism...this marginal space has been a great problem since the beginning of the colonializing experience; rather than being a step in the imaginary "evolutionary process," it has been the locus of paradoxes that called into question the modalities and implications of modernization of Africa. (Mudimbe 1988, 5)

Mudimbe provides a description of the difficulty which arises with Africa's constructed location as the lesser oppressed 'Other' in the dichotomous relationship with Western colonials. Even as African people have freed themselves from colonialism in

the form of a direct colonial state rule, African people and discourses are not disentangled from this historical and continuing experience of domination by and intertwining with Western people, concepts and institutions. This problem forms a great part of the discourse on an African renaissance. What does it mean to be African? Is it possible, or useful, for African people to recreate and reinforce binary discourse, relationships and conceptualisations through a *total* detachment from anything 'Western'? And could it ever be possible to provide a definition of what is *only* Western and what is *only* African?

A goal of complete extraction from Western power, culture and discourse by African people is reasonable in its basis, but illogical in practice, as can be seen in the emergent discourses of the Khomanani publications. The main problem with separating 'African' discourse from that of the 'West' is also the reason this extraction is appealing. Western domination of the world along with its constructions of all non-Western people as 'Other' has resulted in the West's control of many, possibly most, global power structures, and the hegemony of its discourses. If African, or Non-Western, people assert new and resistant conceptualisations, discourses, and structures through a channel of Western information and knowledge production, or into an arena where Western acceptance is necessary or sought, these new or resistant Non-Western assertions will be deemed: unacceptable, ignorant, undeveloped, incorrect, or they will be taken and redefined as Western in inception.

On a less abysmal note, the complete rejection of all that is Western is an untrue representation of what is now African. African people have experienced, and continue to, experience colonialism and its ramifications. African people and discourse is a mix of specifically African culture, philosophy, discourse, and experience, with that of the non-

African as well. African people, are people whose knowledge base is quite cosmopolitan due to a history and continuing experience of multiple interacting national and cultural groups. The discourses of Africa must reflect this mixture of concepts, discourses, and experiences. This is a necessity, not only for a 'true' representation of what is African, but also because it brings together many forms of knowledge and conceptualisations, which is what is most needed in the fight against the world's problems, including HIV and AIDS.

In this way official discourse from the South African government must also reflect a more South African conceptualisation of governmental and human response to the pandemic of HIV and AIDS and everyone affected by the illness. Those people and institutions creating media campaigns, such as Khomanani must work to respond to this localised experience of HIV and AIDS in an expansive way. The work of creating governmental texts must be done with the goal of educating people in order to save their lives, not in either replicating oppressive hegemonic discourses in order to legitimate the government itself, nor as a site within which to engage in discursive battles of competing oppressive power structures.

Works Cited

- Achmat, Zackie and Julian Simcock. 2007. Combining prevention, treatment and care: lessons from South Africa. *AIDS* 21: 11-20.
- Alden, Chris and Mills Soko. 2005. South Africa's economic relations with Africa: hegemony and its discontents. *The Journal of Modern African Studies* 43: 367-392
- Aulette, Judy Root. 2007. *Changing American Families*. Boston, MA: Pearson Education.
- Benatar, Solomon R. 2001. South Africa's Transition in a Globalizing World: HIV/AIDS as a Window and a Mirror. *International Affairs* 77(2):347-375.
- Berberoglu, Berch, David L. Elliot, James F. Petras. 2007. *The State and Revolution in the 20th Century: Major Social Transformations of Our Time*. Lanham, MD: Rowman & Littlefield.
- Bujra, Janet. 2002. Targeting men for a change: AIDS discourse and activism. In *Masculinities Matter*, ed. F. Cleaver. London: Zed Books.
- Butler, Katherine. 2007. President in denial, a ravaged nation denied hope. *The Independent*. <http://www.independent.co.uk> (accessed November, 2008)
- Department of Health. 2005. Khomanani gets behind the test of love. <http://www.info.gov.za/speeches/2005> (accessed March, 2008).
- . 2007. Re-launch of the Khomanani Campaign. <http://www.search.gov.za/info/> (accessed November, 2008)
- . 2008. HIV/AIDS. <http://www.info.gov.za/faq/aids.htm> (accessed November, 2008)

- Diawara, Manthia. 1990. Reading Africa Through Foucault: V.Y. Mudimbe's Reaffirmation of the Subject. *October* 55: 79-92.
- Dlamini, Nozipho. 2007. Khomanani back on track.
<http://www.southafrica.info/about/health> (accessed March, 2008).
- Du Toit, Andre. 1994. On Ideology. *South African Journal of Philosophy* 13: 123-173.
- Evans, Peter B. Evans, Dietrich Rueschemeyer, and Theda Skocpol, eds. 1985. *Bringing the State back in*. Cambridge: Cambridge University Press.
- Fairclough, Norman. 1989. *Language and Power*. NY: Pearson Longman.
- Fauci, Anthony S., Eugene Braunwald, Dennis L. Kasper, Stephen L. Hauser, Dan L. Longo, J. Larry Jameson, and Joseph Loscalzo. 2008. *Harrison's Principles of Internal Medicine 17th Edition*. NY: McGraw-Hill Professional.
- Fasold, Ralph. 1991. *The Sociolinguistics of Language: Introduction to Sociolinguistics*. San Francisco, CA: Wiley-Blackwell.
- Fassin, Didier. 2007. *When Bodies Remember: Experiences and Politics of AIDS in South Africa*. Berkeley: University of California Press.
- Fassin, Didier and Helen Schneider. 2003. The politics of AIDS in South Africa: beyond the controversies. *BMJ* 326: 495-497.
- Foucault, Michel. 1972. *The Archaeology of Knowledge: and the Discourse of Language*. New York: Pantheon Books.
- . 1978. *The history of sexuality: An introduction Volume I*. NY: Vintage.
- . 1908. *Power/knowledge: Selected interviews and other writings 1972-1977*. NY: Pantheon.
- Giddens, Anthony. 1987. *The Nation State and Violence*. Berkeley, CA: University of

California Press.

Hassan, Fatima. 2004. The political struggle to get treatment in South Africa – The last five years. Paper presented at the 15th Annual International Conference on AIDS, July 11-16, 2004, Bangkok, Thailand.

———. 2007. Mother-to-child transmission prevention: Government must improve the programme. *Treatment Action Campaign*. <http://www.tac.org.za> (accessed November 2008)

Heald, Suzette. 2003. An absence of anthropology: critical reflections on anthropology and AIDS policy and practices in Africa. In *Learning from HIV and AIDS*, edited by George Ellison, Melissa Parker and Catherine Campbell, 210-237. Cambridge: Cambridge University Press.

Hill, Michael. 2006. *Social Policy in the Modern World: A Comparative Text*. Boston, MA: Wiley Blackwell.

Jagger, Elizabeth. 1997. The Production of Official Discourse on 'Glue Sniffing'. *Cambridge Journal of Social Policy* 26: 445-465.

Khomanani: Caring Together. 2008a. *Anti-retroviral treatment for life!*. Johannesburg.

———. 2008b. *HIV, AIDS and Rights*. Johannesburg.

———. 2008c. *HIV and AIDS and Treatment*. Johannesburg.

———. 2008d. *HIV and AIDS: Prevention, Care, and Treatment*. Johannesburg.

———. 2008e. *I had and HIV test – now what?*. Johannesburg.

———. 2008f. *Key Points about HIV and AIDS*. Johannesburg.

———. 2008g. *Living with HIV and AIDS*. Johannesburg.

———. 2008h. *Pregnancy and HIV*. Johannesburg.

- . 2008i. *Pregnancy and HIV – what you should know*. Johannesburg.
- . 2008j. *Sexually Transmitted Infections*. Johannesburg.
- . 2008k. *Talking about sexually transmitted infections*. Johannesburg.
- . 2008l. *YOU & HIV/AIDS*. Johannesburg.
- . 2008m. What is Khomanani?
<http://www.healthinsite.net/health/HealthProfile.dll/eCareArticlePop?tp=1&artid=17458> (accessed November, 2008).
- King, Judith. 2002. Writing and Speaking Mindfully in the age of HIV/AIDS.
<http://www.hivan.org.za> (accessed November, 2008).
- Kleintjies, Sharon, Bridgette Prince, Allanise Cloete and Alicia Davids. 2005. Gender Mainstreaming in HIV/AIDS Seminar Proceedings. From seminar proceedings at the 7th AIDS Impact Conference, 2005, Cape Town
- Lessa, Iara. 2006. Discursive Struggles within Social Welfare: Restaging Teen Motherhood. *British Journal of Social Work*. 36: 283-298.
- McHoul, Alec and Wendy Grace. 1993. *A Foucault Primer: Discourse, power and the subject*. NY: New York University Press.
- Medecins Sans Frontieres. 2008. Running in Place: Too Many Patients Still in Urgent Need of HIV/AIDS Treatment. Paper presented at the XVII International AIDS Conference, August, 2008, Mexico City, Mexico.
- Mudimbe, V.Y. 1982. *L'odeur du pere: Essai sur des limites de la science et de la vie en Afrique Noire*. Trans. Manthia Diawara. Paris: Presence Africaine.
- . 1988. *The Invention of Africa: Gnosis, Philosophy and the Order of Knowledge*. Bloomington, IN: Indiana University Press.

- Nattrass, Nicoli. 2007. AIDS denialism vs. science. <http://www.csicop.org> (accessed October, 2008).
- Nattrass, Nicoli. 2003. *The Moral Economy of AIDS in South Africa*. Cambridge: Cambridge University Press.
- Parker, Ian. 2004. Discourse Analysis. In *A Companion to Qualitative Research*, edited by U. Flick, E. Kardoff and I. Steinke, 308-312. London: SAGE Publications.
- Piot, Peter and Awa Marie Coll Seck. 2001. International response to the HIV/AIDS epidemic: planning for success. *Bulletin World Health Organ.* 79(12): 1106-1112.
- Said, Edward. 1978. *Orientalism*. Essex, UK: Vintage.
- Seidel, Gill. 1993. The Competing Discourses of HIV/AIDS in Sub-Saharan Africa: Discourse of Rights and Empowerment vs. Discourses of Control and Exclusion. *Social Science Medicine* 36:175-194.
- Setswe, G. and D. Skinner eds. 2008. *Interventions for orphaned and vulnerable children at four project sites in South Africa*. Cape Town: HSRC Press.
- Skocpol, Theda and Edwin Amenta. 1986. States and Social Policies. *Annual Review of Sociology* 12: 131-157.
- Smith, Davey M., Douglas D. Richman, and Susan J. Little. 2005. HIV Superinfection. *The Journal of Infectious Diseases* 192: 438-444.
- Soul Beat Africa. 2002. Lovelife campaign- South Africa. <http://www.comminiti.com/en/node/119860> (accessed October, 2008).
- . 2003. Beyond Awareness. <http://www.comminiti.com/en/node/125115/38> (accessed October, 2008).
- Soul City. 2008. <http://www.soulcity.org.za> (accessed November, 2008).

- Tallis, V. and D. Cavanagh. 2004. Beyond Gender Mainstreaming: Experiences from South Africa. *Gender AIDS Forum* 9: 1-5.
- Thompson, John B. 1984. *Studies in the Theory of Ideology*. Berkley, CA: University of California Press.
- Therborn, Goran. 2008. *What Does the Ruling Class Do When It Rules?: State Apparatuses and State Power Under Feudalism, Capitalism and Socialism (Radical Thinkers)*. NY: Verso.
- Treichler, Paula. 1999. *How to Have Theory in and Epidemic: Cultural Chronicles of AIDS*. Durham, NC: Duke University Press.
- UNAIDS. 2008. 2008 Report on the Global AIDS Epidemic. <http://www.unaids.org> (accessed November, 2008)
- Wang, Joy. 2008. AIDS Denialism and 'The Humanisation of Africa'. *Race and Class* 49(3): 1-18.
- Zglobiu, Raluca Octavia. 2007. Critical Discourse Analysis Approach. *Studia Universitatis Babes-Bolyai-Philologia* 4:153-158.
- Zungu-Dirwayi, N., O. Shisana, E. Udjo, T. Mosala and J. Seager, eds. 2004. *An Audit of HIV Policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland, Zimbabwe*. Cape Town: HSRC.

Appendix A

Data Set

Booklets used in my data set are grouped as such by Khomanani (Khomanani, 2008) on their website and are as follows:

Accelerate Prevention Booklets A5

Pregnancy and HIV – what you should know

I had an HIV test – now what?

You and HIV/AIDS: know the facts – know the risks

Treatment, Care and Support Booklets A5

HIV and AIDS: Prevention, Care and Treatment

Accelerate Prevention Booklet A4

Talking about sexually transmitted infections

Treatment, Care and Support Booklets A4

HIV and AIDS and Treatment

Anti-retroviral treatment for life!

The z-fold leaflets are similarly grouped by Khomanani (Khomanani, 2008) by theme.

The z-fold leaflets used in my data set are as follows:

Accelerate Prevention Leaflet Z-Fold

Sexually Transmitted Infections (STIs)

HIV, AIDS and Rights

Key Points about HIV and AIDS

Treatment, Care and Support Leaflet Z-Fold

Living with HIV and AIDS

HIV and AIDS in the workplace

Caring for people with HIV and AIDS

Caring together for children

HIV and AIDS counselling

Anti-retroviral treatment (ART)

University of Cape Town

Appendix B

The following are copies of a selection of the booklets and leaflets from the data set. These are included to provide an example of what the texts in the data set actually look like.

University of Cape Town

enziwa ukuhlolwa kwegazi ukuze kutholakale umuntu unaso yini isandulela-ngculazi.

Voluntary Counseling and

ing Site

AIDS Training, Information and Counselling Centre
ising: amadolobha amakhulu

uphiqelelwa ukuba wenziwe ukuhlolwa kokuthi

ni isandulela-ngculazi noma cha,

okumelwa uzikhethile. Imiphumela

iyimfihlo, futhi ngawena kuphela

va ngayo. Lokhu kuhlolwa kuyokusiza

thilele ikusasa lakho, futhi kuvumbele

izeka kwegciwane lesandulela-

ukungenwa yigciwane

ulela-ngculazi:

"cha" kwezonsansi.

uthembekile koya naye ocansini.



• Tsebenzisa ngandlwa etanle ikhondomo njalo nje isipho uyil ocansini.

• Buzisa isisacenzi sasemtholampilo ngazingazi zegciwane lesandulela-ngculazi uma ukubiliwe.

• Vimbela ukuthintana negazi. Sebenzisa amagilavu, izikhwama zepulasitiki noma ezinye izinto eziphephile.

Alkho ikhamo lengculazi. Kodwa abantu abanengi abanegciwane lesandulela-ngculazi baphila impilo enhle isiknathi eside. Bayayinakekela impilo yabo, bazigcine beyimqemane, bathole ukwelashwa uma begula, badle ukudla okufanele, bagweme ukucindezeleka futhi baye ocansini ngendlela ephhephile.

Uma kukhona imibuzo onayo ngesandulela-ngculazi nengculazi, shayela i-AIDS Helpline yamahhala esebenza amahora angu-24 kule nombolo ethi 0800 012 322. Kunamanye amapheshana kulolu chungechunge anikeza ukwazi owengeziwe ngesandulela-ngculazi, ingculazi, nezifo ezithathelwana ngocansi (STIs).

ka dilemo tse ngata pele matshwao a HIV a atsatsa. Hona ho etsahlala hangata ha motho a ka ke mafu a mang.

ka HIV ya madi e ka etswa:

hiking kapa ngakeng

keng sa Fanang ka Keletso e sa Lefellweng eko

- setsing sa Tsupelo, Tihahiso-leseding le Keletso mabapi le AIDS, se furnanehang ditoropong tse ngata

O ke ke wa qobellwa ho etsa teko ya HIV. Ke kgetho ya hao. Diphelelo di tla bolokwa e le lekunutu. Imne ke wena feela ya tla tsebiswa ka tsona. Teko e tla o thusa ho rera bokamoso ba hao, le ho thibela ho nana HIV.

Thibela tshwaetso ya HIV:

- Ka ho hana ho etsa thobalano (diphate).
- Tshepahala ka dinako tsohle ho molekane eo o robalang le yena.

- Nako e nngwe le e nngwe ha o etsa thobalano le molekane wa hao sebedisa khondomo ka mokgwa o nepahetseng.
- Botsa mosebetsi wa bophelo bo botle ka dikotsi tse amanang le HIV ha o le moimana.
- Qoba ho ama madi. Sebedisa ditlalafo, mekotlana ya polasetiki kapa dithibelo tse ding.

Ha ho na pheko ya AIDS. Empa batho ba bangata ba tsiwaeditsweng ke HIV ba dula nako e telele ba phetse hantle. Ba hlokomela bophelo ba bona, ba dula ba shahlile, ba batla pheko ho ba kula, ba ja dijo tse nepahetseng, ba qoba kgatele ya maikutlo le ho etsa thobalano le molekane ka mokgwa o sireletsenileng.

Haeba o na le dipotso leha e le dife tse mabapi le HIV le AIDS, o ka letsetsa nomorong ya mahala e sebensang dihora tse 24 ya AIDS Helpline 0800 012 322. Ho na le dipampitshana tse ding tse letotong lena tse fanang ka tihahiso-leseding e eketsehileng mabapi le HIV, AIDS le mafu a tshwaetsanwang ka thobalano (diphate).

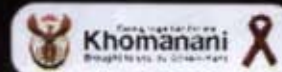
Caring together for life
Khomanani

Key points about HIV and AIDS

AFRIKAANS Belangrike feite oor MIV en VIGS

isiZulu Amaphuzu Abalulekile Ngesandulelangculazi Nengculazi

SESOTHO Dintlha tsa Bohlokwa ka HIV le AIDS



Red Ribbon Resource Centre
(011) 880-0405
AIDS Helpline 0800 012 322
www.khomanani.org.za

ENGLISH: Key Points about HIV and AIDS

AIDS is a disease that affects millions of South Africans. It is caused by a virus called HIV that makes it difficult for a person to fight off other diseases.

HIV is spread from one person to another:

- by having unprotected sex with an infected person
- through contact with infected blood
- from an infected mother to her unborn or newborn baby (not all babies born to infected mothers become infected with HIV)

HIV is NOT spread by coughing, hugging or touching.

Most people infected with HIV do not know it. You cannot tell just by looking at them.

It can take many years for the signs of HIV to show. This is usually when a person becomes ill from other diseases.

An HIV blood test can be done:

- at clinics or by a doctor
- at a Voluntary Counselling and Testing Site
- at an AIDS Training, Information and Counselling Centre in most cities

You cannot be forced to have an HIV test. It is your choice. The results are confidential, and only told to you. The test will help you to plan your future, and to prevent the spread of HIV.

Prevent HIV infection:

- Say "no" to sex.
- Stay faithful to your sexual partner.



- Use a condom correctly every time you have sex.
- Ask a health worker about HIV risks if you are pregnant.
- Prevent contact with blood. Use gloves, plastic bags or other barriers.

There is no cure for AIDS. But many people will live long healthy lives. They take care of their health. They keep fit, get treatment when they are sick, eat correct food, avoid stress and practise safer sex.

If you have any questions about HIV and AIDS, you can phone the free 24-hour Helpline at 0800 012 322. There are also leaflets in this series that give more information about HIV, AIDS and STIs.

AFRIKAANS: Belangrike feite oor MIV en VIGS

VIGS is 'n siekte, wat miljoene Suid-Afrikaners affekteer. Dit word veroorsaak deur 'n virus genaamd MIV, wat dit vir 'n persoon moeilik maak om ander siektes af te weer.

MIV word van een persoon na 'n ander oorgedra

- deur onbeskermd seks met 'n geïnfecteerde persoon te hê;
- deur kontak met geïnfecteerde bloed;
- van 'n geïnfecteerde moeder aan haar ongebore of pasgebore baba (nie alle babas van geïnfecteerde moeders word met MIV geïnfecteer nie).

MIV word NIE deur hoë, omhelsing of aanraking versprei nie. Die meeste mense, wat met MIV geïnfecteer is, weet dit nie. Jy kan ook nie weet of hulle met MIV geïnfecteer is nie, deur net na hulle te kyk.



Dit kan baie jare duur, voordat die tekens van MIV sigbaar word. Dit is gewoonlik wanneer 'n persoon aan ander siektes ly.

'n MIV-bloedtoets kan uitgevoer word:

- by klinieke, of by 'n dokter;
 - by 'n vrywillige berading-en-toets-sentrum;
 - by 'n VIGS-opleiding-, inligting- en beradingsentrum, in die meeste stede.
- Jy kan nie gedwing word, om 'n MIV-toets te ondergaan nie. Dit is jou keuse. Die uitslag is vertroulik en word net aan jou meegedeel. Die toets sal jou help, om jou toekomst te beplan en om te help keer, dat MIV versprei.

Voorkom MIV-infeksie:

- Sê "nee" vir seks.
- Bly getrou aan jou seksmaat.

- Gebruik 'n kondoom op die regte manier, elke keer as jy seks het.
- Vra 'n gesondheidswerker oor die MIV-risiko as jy swanger is.
- Voorkom kontak met bloed. Gebruik handske, plastieksakke of ander skeidingsmiddels.

VIGS kan nie genees word nie. Baie mense met VIGS leef nogtans lang, gesonde lewens. Hulle kyk na hulle gesondheid, bly fiks, kry behandeling wanneer hulle siek is, eet die regte kos, vermy spanning en beoefen veiliger seks.

As jy enige vrae oor MIV en VIGS het, kan jy die gratis 24-uur VIGS-hulplyn bel, by 0800 012 322. Daar is ander blaadjies in hierdie reeks, wat meer inligting oor MIV, VIGS en SOI's verskaf.



OLD
MUTUAL

[illegible]

Prevention, Care and Treatment



How does stigma and discrimination fuel the epidemic?

Out of fear of stigma and discrimination, many people deny there is a problem or may not disclose or acknowledge their status. This results in:

- The epidemic remaining largely invisible. People have a false sense of security, thinking there is no risk.
- People not using condoms.
- People fearing being tested, especially if they think they may be HIV positive.
- People who are living with HIV not getting care or treatment for fear that their status will be disclosed, or that they will be turned away from health centres.
- Undue stress being put on people living with HIV. This can speed up the onset of AIDS.

How does the provision of treatment, care and support help reduce stigma?

The provision of treatment, care and support provides more hope and gives people the incentive to have an HIV test to find out their HIV status. This creates a climate of openness. With treatment, HIV will become more like any other chronic disease (like diabetes or high blood pressure), which can be managed and lived with for long periods of time. Attitudes and perceptions of HIV will then hopefully be normalised.



Gender

Both physical and socio-economic factors make women and girls more vulnerable to HIV.

Why are women physically more vulnerable to HIV than men?

The vagina has large areas of exposed and sensitive skin, which can get cut during sex. This allows HIV to enter the body more easily. Semen also stays longer in the vagina after sex, increasing the risk of transmission.

The penis has a small surface area, which is in contact with the vaginal fluids for a shorter time. This means that a man's risk of contracting HIV is lower than that of a woman.

Some women may not be aware that they have a sexually transmitted infection as certain STIs do not cause symptoms in women. The presence of these STIs still increases their vulnerability to HIV infection.

What are the socio-economic factors that place women at risk?

The socio-economic status of women places them at a higher risk of HIV infection due to the fact that:

- Many women cannot choose to abstain, use a condom, or insist on other forms of safer sex, because this may result in violence or abandonment by their male partners.
- Rape contributes greatly to the spread of HIV because of the risk of trauma to the vagina. This risk obviously increases in the event of gang rape.
- Poverty forces many women into sex-work in order to survive and support their children.
- Some men are reluctant to visit hospitals and clinics when they have sexually transmitted infections. Many also blame their woman partner for having an STI. The violence that may follow also discourages women from telling their partners they have an STI. This can result in a recurrence of the STI.

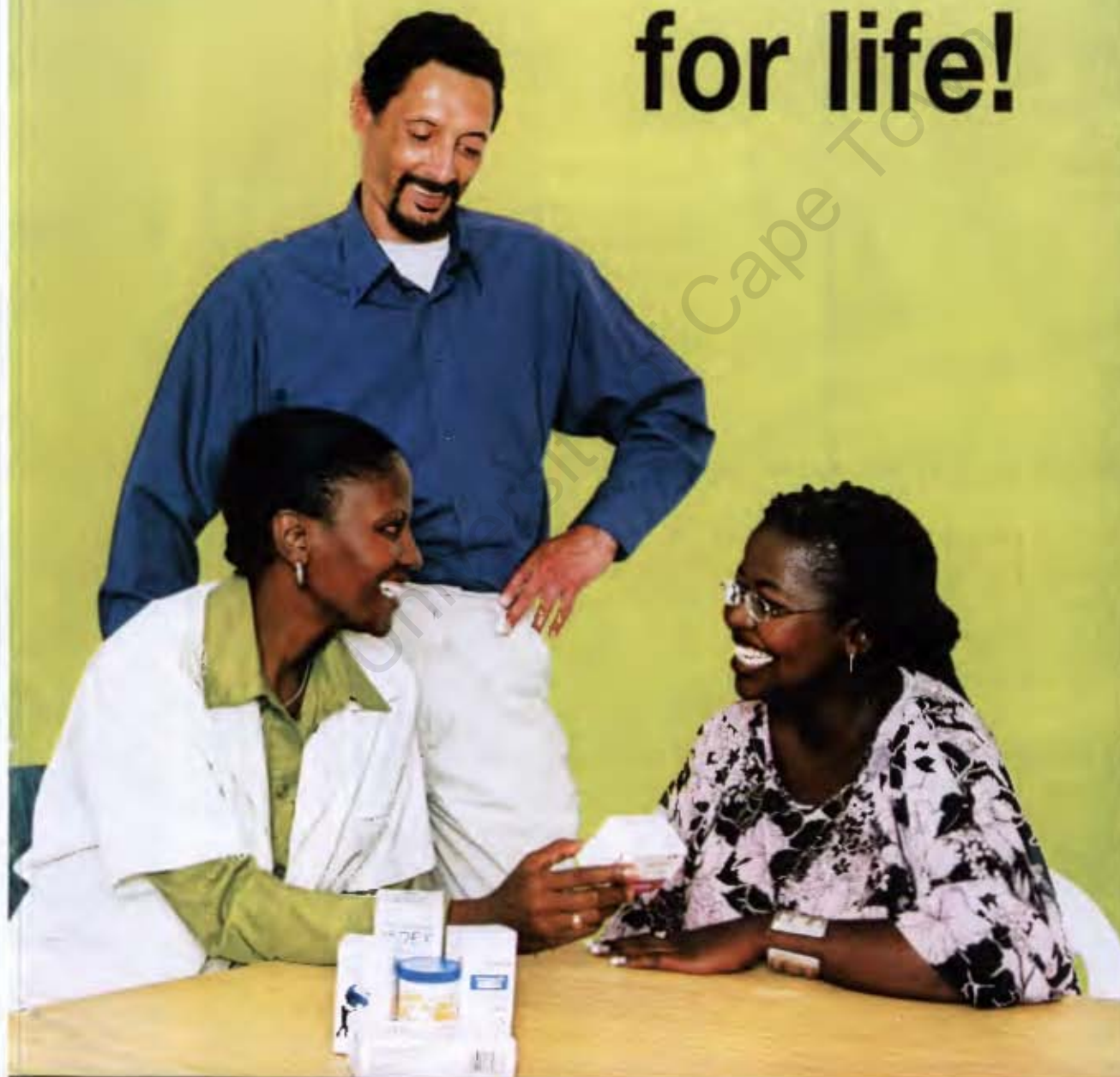
Soul City

It's Real

Caring together for life

Khomanani

Anti-retroviral treatment for life!



Caring together for life
Khomanani
Brought to you by Government



Red Ribbon Resource Centre

011 880 0405

AIDS Helpline 0800 012 322

www.aidsinfo.co.za

How to make ART



There are 5 important things that can help ART work well for you.

These are the 5 Ts:

1. Truth
2. Treatment plan
3. Treatment helper
4. Treatment record
5. Trust

1. Truth

Personal issues

- kokuqondana nawe
- imibandela eyeyakho
- tse hlakolosi
- personlike sake



- Be 100% honest about any personal issues like sex, alcohol and drug use.
- If you are honest, there is more chance that ART will work for you.
- The health worker is there to help you and not to judge you.



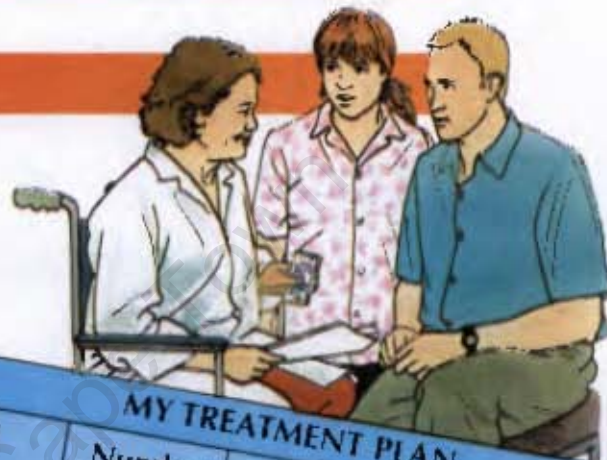
Answer all questions truthfully. Your health worker will then know all the facts and problems you may have about sticking to your treatment. For more about you and your health worker, turn to pages 28 to 29.

work for you

2. Treatment plan

Your health worker will work with you to develop a treatment plan. This will remind you:

- which pills to take
- how many to take
- when to take them
- whether to take them with food or on an empty stomach.



MY TREATMENT PLAN			
Name of ARV	Number of pills	When	Comments
d4T	1	8am to 8pm (every 12 hours)	
3TC	1	8am to 8pm (every 12 hours)	
EFV	3	8pm (in the evening)	Avoid taking pills with a fatty meal



Get a treatment plan from your clinic if they have one. You can also use the example here to write your own.

3. Treatment helper

Tell someone you trust that you are starting ART. Ask this person to be your treatment helper. This person will do three important things for you:

1. **Remind** you to take your medicines every day.
2. **Help** you if you have side-effects.
3. **Come** with you to see a health worker if you don't want to go alone.

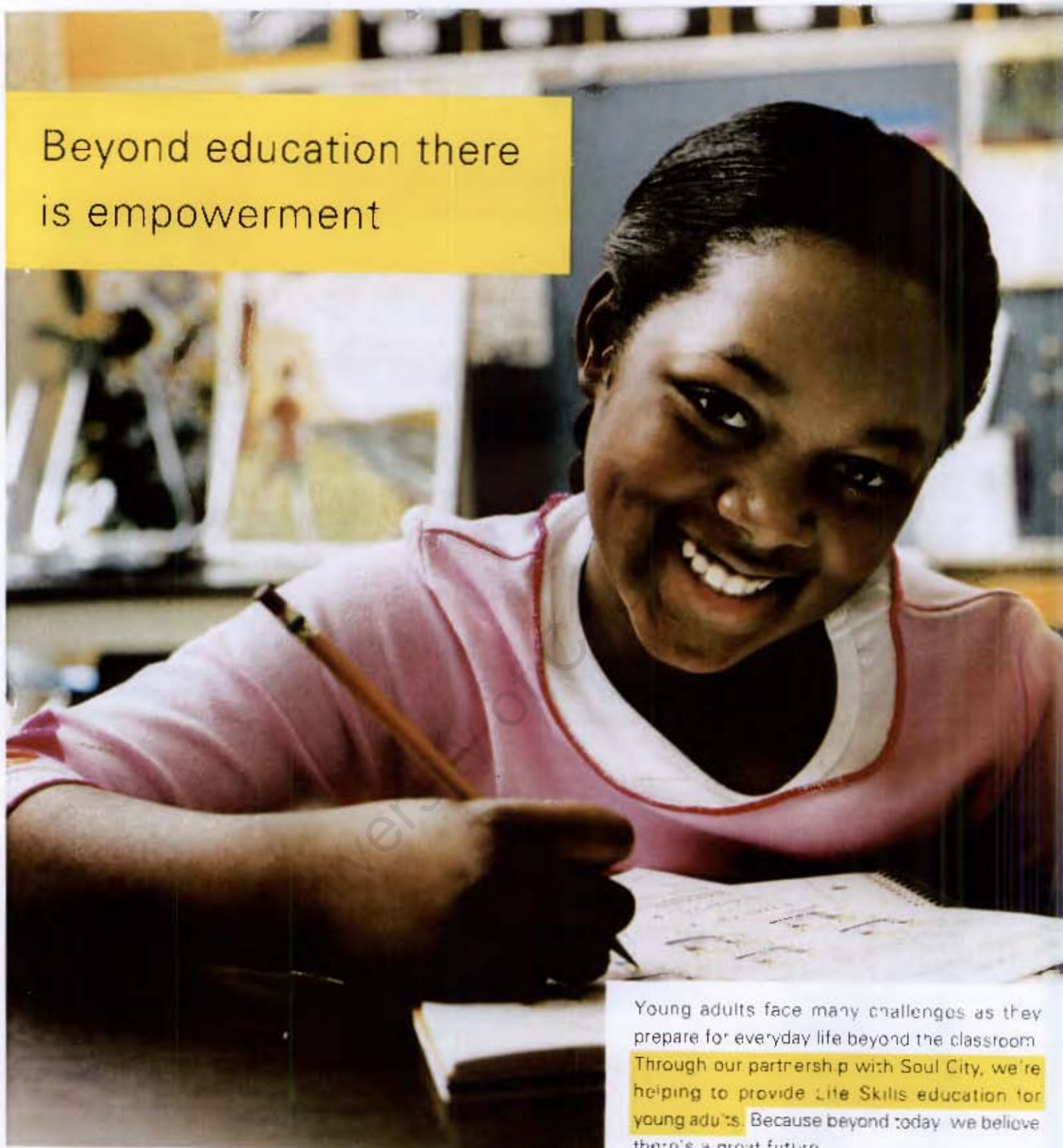


Remind
• khumbuze
• khumbuze
• ho o hopo
• herinner

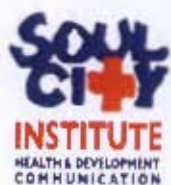


Choose a family member you trust or a friend that lives close to you. Ask that person to find out more about ART and to be your treatment helper.

Beyond education there
is empowerment



Young adults face many challenges as they prepare for everyday life beyond the classroom. Through our partnership with Soul City, we're helping to provide Life Skills education for young adults. Because beyond today, we believe there's a great future.



beyond petroleum™

bp.com